State of Alaska FY2009 Governor's Operating Budget

Department of Health and Social Services
Performance Measures

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Department of Health and Social Services

Mission

To promote and protect the health and well being of Alaskans.

Core Services

- Provide quality assisted living in a safe home environment.
- Provide an integrated behavioral health system.
- Promote stronger families, safer children.
- Manage health care coverage for Alaskans in need.
- Address juvenile crime by promoting accountability, public safety and skill development.
- Promote self-sufficiency and provide basic living expenses to vulnerable Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote independence of Alaska Seniors and people with physical and developmental disabilities.
- Provide quality administrative services in support of the Department's mission.

While the core services serve as the basis for the department's service delivery system the Department has three main guiding principles: self sufficiency for Alaskans, a strong safety net for those who cannot provide for themselves, and local access to care.

End Result	Strategies to Achieve End Result
A: Outcome Statement #1: Provide a safe living environment for elderly pioneers and veterans.	A1: Provide sufficient staffing for safe environment in the homes.
Target #1: Injury rate below half the national standard, which is two to six percent. Measure #1: Pioneers Home sentinel event injury rate.	
End Result	Strategies to Achieve End Result
B: Outcome Statement #2: Improve and enhance the quality of life for Alaskans with serious behavioral health problems.	B1: Provide enhancements to prevention and early intervention services.
Target #1: To reduce the number/percentage of children in out-of-state placement by 50 children annually over the next seven years.	
Measure #1: Change in number/percentage of children reported in out-of-state care from Medicaid MMIS.	
Target #2: To reduce the rate of suicides in Alaska to 10.6 deaths per 100,000 population. Measure #2: Alaska's suicide death rate compared to national rate.	
Target #3: Reduce 30 day readmission rate for API to 10%.	
Measure #3: Rate of API readmissions.	

End Result	Strategies to Achieve End Result
C: Outcome Statement #3: Children who come to the attention of the Office of Children's Services are, first and foremost, protected from abuse or neglect.	C1: Implementation of new safety assessment model to provide front line workers with a better tool to identify safety issues in the home.
Target #1: Decrease the rate of substantiated allegations of child abuse and neglect in Alaska. Measure #1: The rate of child abuse and neglect per 1,000 children under the age of 18.	C2: Children placed outside of the home are protected from further abuse and neglect. C3: Retain an effective and efficient workforce.
Target #2: To decrease the rate of repeat maltreatment to meet or exceed the national standard of 6.1 percent. Measure #2: Percentage rate of repeat maltreatment.	oo. Retain an encouve and emolent worklorde.
Target #3: Decrease the percentage of substantiated maltreatment by out-of-home providers. Measure #3: Percentage of children maltreated by an out-of-home provider.	
Target #4: Reduce the rate of staff turnover and increase the number of workers providing direct services at any given time. Measure #4: Annual employee turnover rate; number of	
positions available to provide direct services. End Result	Strategies to Achieve End Result
End Result	otrategies to Admeve Ena Result
D: Outcome Statement #4: To provide quality management of health care coverage services to providers and clients.	D1: Continue to develop new Medicaid Management Information System (MMIS).
Target #1: Decrease average response time from	
receiving a claim to paying a claim. Measure #1: Average number of days per annum from receipt of claims to payment of claims.	
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receiving a claim to paying a claim. Measure #1: Average number of days per annum from receipt of claims to payment of claims. Target #2: Increase the percentage of adjudicated claims paid with no provider errors. Measure #2: Change in the percentage of adjudicated	
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Measure #1: Percentage change in reoffense rate following release from institutional treatment.	
Target #2: Reduce percentage of juveniles who reoffend following completion of formal court-ordered probation supervision to less than 33%. Measure #2: Percentage change in re-offense rate following completion of formal court-ordered probation supervision.	
Target #3: Alaska's juvenile crime rate will be reduced by 5% over a two-year period. Measure #3: Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.	
Target #4: Divert at least 70% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses. Measure #4: The percentage of referrals that are	
managed through informal processes. End Result	Strategies to Achieve End Result
F: Outcome Statement #6: Low income families and individuals become economically self-sufficient.	F1: Use TANF high performance bonus funds for families approaching 60-month time limit.
Target #1: Increase self-sufficient individuals and families by 10% annually. Measure #1: Rate of change in self-sufficient families.	
End Result	Strategies to Achieve End Result
G: Outcome Statement #7: Healthy people in healthy communities.	G1: Strengthen public health in strategic areas.
Target #1: 80% of all 2 year olds are fully immunized. Measure #1: % of all Alaskan 2 year olds fully immunized.	
Target #2: Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010. Measure #2: Three year average post-neonatal mortality rate (Post-neonatal is defined as 28 days to 1 year).	
Target #3: Decrease diabetes in Alaskans. Measure #3: Prevalence of Diabetes among Adults (18+) in Alaska based upon three-year averages.	
Target #4: Decrease Alaska's adult obesity rate to less than 18%. Measure #4: Obesity rate of Alaskans.	
End Result	Strategies to Achieve End Result
H: Outcome Statement #8: Senior and physically	H1: Promote independent living and provide

and/or developmentally disabled Alaskans live independently as long as possible. Target #1: Increase the number of DD waiver recipients receiving Supported Employment Services. Measure #1: % change of beneficiaries receiving supported employment services under Developmental Disabilities Waiver.	preadmission screening to nursing homes.
End Result	Strategies to Achieve End Result
I: Outcome Statement #9: The efficient and effective delivery of administrative services. Target #1: Reduce the average response time for	
complaints/inquiries to 14 days. Measure #1: Department Inquiry/Complaint "HSS Track" log response times.	
Target #2: Reduce by 5% per year processing time for key indicators. Measure #2: Track number of days it takes to process: Purchase Requisitions; Operating Grant Awards; Processing Time for Payments; Capital Grant Awards; and Legislative inquiries.	

FY2009 Resources Allocated to Achieve Results			
FY2009 Department Budget: \$2,147,187,000	Personnel: Full time	3,447	
	Part time	98	
	Total	3,545	

Performance Measure Detail

A: Result - Outcome Statement #1: Provide a safe living environment for elderly pioneers and veterans.

Target #1: Injury rate below half the national standard, which is two to six percent. **Measure #1:** Pioneers Home sentinel event injury rate.

Alaska Pioneer Home Sentinel Event Injury Rate

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	2.9%	0.7%	0%	0.37%	.99%
2003	1.1%	.04%	1.79%	1.5%	1.1%
2004	1.96%	0.1.26%	0.97%	1.47%	1.45%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2007	3.5%	1.2%	2.0%	2.1%	2.2%
2008	1.5%	0	0	0	0
		0%	0%	0%	0%

The Sentinel Event injury rate reports the percentage of falls that resulted in a major injury. The rate is calculated by dividing the number of

Sentinel injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: The elderly, who represent 12 percent of the population, account for 75 percent of deaths from falls.

The average age in the Pioneer Homes is 84.9. This puts the residents in the highest risk category, and they are more likely to suffer a serious injury from a fall, and experience significant morbidity thereafter.

The Pioneer Homes will respond to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problem is even more disturbing. The event is called "sentinel" because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization as other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to \$32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

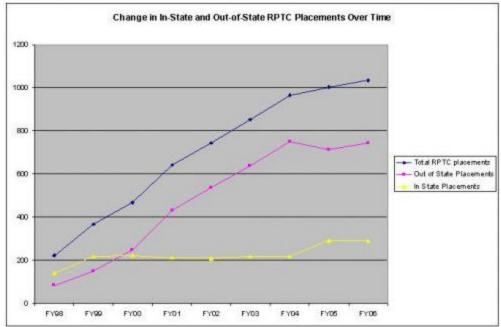
See Alaska Pioneer Homes Division Level Strategy A2: Target 1: Measure 1 for additional explanation.

A1: Strategy - Provide sufficient staffing for safe environment in the homes.

B: Result - Outcome Statement #2: Improve and enhance the quality of life for Alaskans with serious behavioral health problems.

Target #1: To reduce the number/percentage of children in out-of-state placement by 50 children annually over the next seven years.

Measure #1: Change in number/percentage of children reported in out-of-state care from Medicaid MMIS.



Source: DBH Policy and planning using MMIS-JUCE data, unduplicated count of RPTC beneficiaries.

Analysis of results and challenges: For the past eight years there has been a steady increase in the number of children receiving out-of-state Residential Psychiatric Treatment Center (RPTC) services. Between FY 1998 and 2004, the unduplicated number of youth with Serious Emotional Disorders (SED) receiving out-of-state RPTC care has steadily increased — on average 46.7% per year. The RPTC population

FY2009 Governor

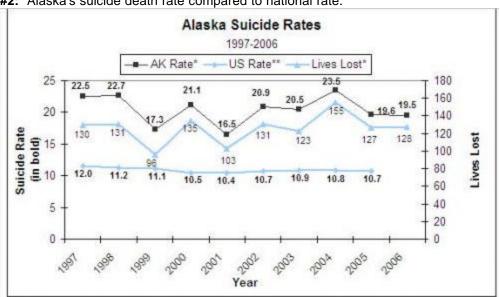
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as a whole has also showed steady increase from FY 98-04, an average annual increase of 24.8%.

The Bring the Kids Home Project was initiated during FY 2004. Positive changes are already apparent. Between FY 2004 and 2005 there was a 5.1% reduction in the number of children receiving out-of-state RPTC care, from 749 to 711. However, between FY 2005 and 2006, there was again an increase in out-of-state placement, of 5%, from 711 to 743. In FY 2006, there was a 3% increase in total RPTC placements. The historical average increase of 46.7% for out-of-state placements has been effectively challenged with the efforts to enhance "step-down" activities, that is, programs for children that are less intensive, less restrictive, and closer to home, than out-of-state residential programs.

Alaska Statute 47.07.032 requires that the department may not grant assistance for out-of-state inpatient psychiatric care if the services are available in the state. To that end, the department has developed and implemented "diversion" activities, including aggressive case management services that discharge and return children to less restrictive levels of care; utilization review staff implementing gate-keeping protocols with a "level of care" instrument that ensures appropriate placements; and collaboration with community-based providers to augment services at the least restrictive level within a client's home community. There have also been multiple capital projects initiated to increase the number of beds in-state, some of which became available in FY 07. As more new beds and other programs become available, it is anticipated that there will be further impact on the rate of out-of-state placements. This project is a collaboration of the Division of Behavioral Health, Division of Juvenile Justice and Office of Children's Services, in partnership with the Alaska Mental Health Trust Authority.

Target #2: To reduce the rate of suicides in Alaska to 10.6 deaths per 100,000 population. **Measure #2:** Alaska's suicide death rate compared to national rate.



Rates are age-adjusted per 100,000 population.

^{*}The Alaska rate and lives lost count for 2006 are preliminary.

[™]U.S. suicide rate for 2005 is preliminary and 2006 data is unavailable at time of publication

Rate of Suicides 1998-2006

Year	Alaska Rate	Lives Lost	US Rate
1998	22.7	131	11.2
1999	17.3	96	11.1
2000	21.1	135	10.5
2001	16.5	103	10.4
2002	20.9	131	10.7
2003	20.5	123	10.9
2004	23.5	155	10.8
2005	19.6	127	10.7
2006	19.5	128	N/A

*Rate is number per 100,000 standard population and accounts for differences in population distribution.

Analysis of results and challenges: Alaska averages 125 suicides per year and has a suicide rate double the national suicide rate. The Healthy Alaskan 2010 target is to reduce Alaska's rate to 10.6 deaths per 100,000 populations. The suicide rate for Alaska in 2006 shows a slight decline in rate, however is still much higher than the target. This measure reflects a system-wide problem that takes coordination between state agencies, community providers, school districts and faith-based organizations.

Work continues to better understand the underlying causes of suicide of Alaskans. The Statewide Suicide Prevention Council partners with the Department of Health and Social Services, Division of Behavioral Health to provide training on the Statewide Suicide Prevention Plan and assessing community readiness for decreasing suicide and non-lethal suicidal behaviors. The Division of Behavioral Health has done the following: required all community-based suicide grantees align their suicide prevention efforts with the Suicide Prevention plan; conducted a presentation on community-based planning implementing effective strategies aligned with the statewide plan; and coordinated with Native health corporations, police, chaplains, and other groups to assist in suicide prevention or coping program design.

An interim report of the Suicide Follow-Back Study shows the following system-wide factors, based on a limited number of interviews, of those related to or close to those who had died by suicide:

54% had guit working during the preceding year;

47% were seeing a therapist at the time of their death;

59% had current prescriptions for mental health problems;

65% experienced an event that caused a great deal of shame (such as sexual abuse, child porn, an arrest, etc.);

61% had problems with law enforcement;

20% were abused as children – 80% by their fathers;

50% were seen by a doctor in the last six months;

46% had symptoms of post traumatic stress disorder (PTSD);

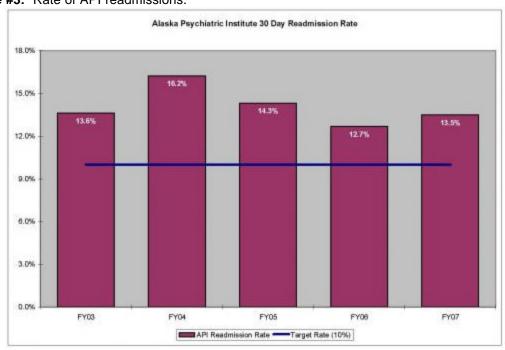
62% were active smokers;

33% had prior suicide attempts; and

20% had recent exposure to suicide of a loved one.

The rate of suicides and number of deaths is higher in the Northern/Interior and Southwest regions of Alaska and is more predominant in the 15-24 age groups. The overall age span with highest suicide incidents is 15-24.

^{*}CY 2006 Alaska data is preliminary; U.S. Data for 2006 is not available.



Target #3: Reduce 30 day readmission rate for API to 10%. **Measure #3:** Rate of API readmissions.

Analysis of results and challenges: This measure tracks the percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8% of all admissions were readmissions. This measure not only is an indication of successful outcomes for API, but also of the mental health community system. The ultimate goal is to have Alaska's rate fall below 10%.

According to data for FY 07, API and the 'system' continue to demonstrate unsatisfactory outcomes. API relocated to a new hospital in July 2005. The success of a 'downsized' state psychiatric hospital was predicated on increased funding for community providers and establishing 18 designated evaluation and treatment beds in Anchorage. These initiatives did not receive planning or funding. As a result, API comes under increasing pressure to shorten length of stays for acutely ill psychiatric patients who ultimately return to the hospital due to lack of adequate supportive housing and treatment options. In FY07, API admitted 1,231 patients of whom 166 returned within 30 days for a 13.5% readmission rate.

B1: Strategy - Provide enhancements to prevention and early intervention services.

C: Result - Outcome Statement #3: Children who come to the attention of the Office of Children's Services are, first and foremost, protected from abuse or neglect.

Target #1: Decrease the rate of substantiated allegations of child abuse and neglect in Alaska. **Measure #1:** The rate of child abuse and neglect per 1,000 children under the age of 18.

Rate of Child Abuse and Neglect Per 1,000 Children Under Age 18 in Alaska

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Year	Rate Per 1,000	National Rate	
FY 2006	23.8	11.9	
FY 2007	24.1	11.9	
	+1.26%	0%	

FY 2006 measures forward represent an unduplicated number of children with substantiated abuse or neglect per 1,000 children in the population. The population equals the number of children under the age of 18 years as estimated by the Department of Labor and Workforce Development during the year prior to reporting.

Source: Target of 11.9 - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment. 2004.

Analysis of results and challenges: The Office of Children's Services goal is to protect children from abuse and neglect. Measuring the success of children's services agencies can be done, in part, through the number of substantiated child protective services reports received per 1,000 children under the age of 18 in the state.

In FY 2004, national levels of substantiated abuse and neglect per 1,000 children was calculated by Child Trends Databank at 11.9 and averaged 12.2 over five years. This places Alaska's victim rate at 31% higher than the national average.

The Office of Children's Services is continuing to implement our new safety decision making practice. The new model has proved to be more of a paradigm shift than was previously anticipated; therefore the implementation of new practice standards is taking longer than originally anticipated. The new model of working with families will lead to improved outcomes for the children and families needing OCS intervention. New practice standards have revealed that additional specialized training is necessary and is being pursued through the University of Alaska.

One of the fundamental differences in the new model requires workers to do an assessment of the entire family and their overall functioning and to look beyond whether the abuse or neglect is substantiated or not substantiated. In the past, workers focused just on the maltreatment itself and did not address other issues going on in the home. This resulted in missed opportunities to engage families in remedial services to avoid subsequent abuse and neglect to the child. Further, the new model helps workers to understand the essential differences in whether the child is unsafe or at risk. Unsafe determinations require OCS intervention, while risk factors may necessitate a referral to community resources. This will result in better identification of families that must be served by the child protective services system versus those that can be served by other resources.

Target #2: To decrease the rate of repeat maltreatment to meet or exceed the national standard of 6.1 percent.

Measure #2: Percentage rate of repeat maltreatment.

Rate of Repeat Maltreatment

Year	YTD	Target
2005	10.6%	6.1%
2006	10.4%	6.1%
2007	11.4%	6.1%

Data Source: National Child Abuse and Neglect Data System and Alaska's Online Resources for the Children of Alaska (ORCA).

Analysis of results and challenges: The federal guideline for repeat maltreatment includes all children who are victims of substantiated child abuse and/or neglect twice during a six-month period. Because Alaska's rate of repeat maltreatment has been so high, a protocol was developed to more closely examine past investigations resulting in a substantiated finding of abuse or neglect. If there have been past substantiated investigations, the OCS worker will review the previous record to ascertain whether the newly reported allegations are against the same child by the same maltreater. If so, the worker and his/her supervisor will devise a strategy for intervention for the current investigation acknowledging that there may be a pattern of abuse that needs to be recognized. The supervisor will closely monitor the progress of the investigation and ensure the appropriate actions are taken to protect the child from further abuse.

The OCS anticipates improvements in the number of repeat maltreatment cases not only due to the improved business practices set out above.

Business practices continue to be upgraded as the OCS is receiving technical assistance from the Annie E. Casey Foundation to improve foster care and the approach to foster care. In addition, the OCS is restructuring the administration of foster care and adoptions by moving all of the work to one section and moving the supervision and decision making from the field up through state office to alleviate any conflicts of interest.

Target #3: Decrease the percentage of substantiated maltreatment by out-of-home providers. Measure #3: Percentage of children maltreated by an out-of-home provider.

Percentage of Children Maltreated by an Out-of-Home Care Provider

Year	FFY % Rate	National Rate
FFY 2005	1.10%	0
FFY 2006	1.16%	.57%
FFY 2007	1.55%	.57%

Source: Online Resources for the Children of Alaska (ORCA) data system for the National Child Abuse and Neglect Data System (NCANDS) and federal Adoption and Foster Care Analysis and Reporting System (AFCARS).

Source: Target of .57% - United States Department of Health and Human Services Administration for Children and Families. Child Maltreatment, 2004.

Analysis of results and challenges: Steady increases are believed to be an indicator that there are not enough foster homes. The pool of resources from which to make the best possible match for children needing placement and foster parents best able to meet the needs of a particular child is too small.

OCS continues to work toward improved business practices through the use of technical assistance and increased foster and child care rates to assure foster parents will not need to continue to absorb the cost of care for foster children.

Target #4: Reduce the rate of staff turnover and increase the number of workers providing direct services at

Measure #4: Annual employee turnover rate; number of positions available to provide direct services.

Office of Children's Services Vacancy /Turnover Rates & the Number of Positions Filled

Year	Vacancy Rate	Turnover Rate	Avg. # Positions Filled	Turnover Target
FY 2004	6.28%	32%	218	0
FY 2005	10.44%	38%	249	0
FY 2006	11.35%	30%	261	0
FY 2007	9.5%	33%	261	20%

This vacancy and turnover analysis is an update of past analysis and is based on the same methodology used by the Department of Administration, Division of Personnel in compiling their workforce analysis. Vacancy and turnover analyses are based on vacancies in the Children's Services Specialist I, II, and III and the Social Worker (CS) I, II, III, and IV job class series. Data is collected from the State of Alaska Payroll System. This analysis compiles complete fiscal year data.

Turnover rate represents the number of times a position becomes vacant in the Frontline Social Worker component due to an incumbent leaving the position. Reasons for leaving include, but are not limited to, resignation, separation, termination, voluntary demotion, promotion, retirement, or non-retention.

Vacancy rate represents the total number of positions vacant divided by the number of positions in the job class series. The analysis compiles data from the fiscal year and records the length of time a position is vacant so that multiple vacancies for any one position are counted.

Analysis of results and challenges: The Office of Children's Services received the final report in May 2006 for a work load study completed by Hornsby Zeller Associates, Inc. One of the recommendations was that OCS not engage in wide-scale changes to personnel that would include transferring positions from overstaffed offices to understaffed offices until such time as data regarding caseload and workload trends could be established. However, the contractor did conclude that in order to meet the workload of the state, OCS needed an additional 17 positions to handle the state's entire caseload as mandated by state and federal policy guidelines. The OCS received authorization for 6 new positions in FY 2008:

- 2 Community Care Licensing Specialists
- 3 Children's Services Specialists
- 1 Social Worker

No administrative staff has been added, which has caused a burden to front line staff having to pick up administrative tasks.

Work on a comprehensive plan to address retention, recruitment and selection of front line staff continues. OCS has not yet realized the kind of success needed from retention and recruitment efforts. There are a number of efforts currently underway and the plan is constantly evaluated and revised as new ideas and efforts are explored.

This measure has been enhanced by adding vacancy rates and the average number of direct service positions filled. Turnover rates, while extremely high and disruptive, do not provide a complete picture. OCS added vacancy rates as a measure of positions vacant at any given time through a year and filled positions to show that while turnover and vacancy rates remain high, progress in the number of available workers at any time has improved.

- C1: Strategy Implementation of new safety assessment model to provide front line workers with a better tool to identify safety issues in the home.
- C2: Strategy Children placed outside of the home are protected from further abuse and neglect.
- C3: Strategy Retain an effective and efficient workforce.
- D: Result Outcome Statement #4: To provide quality management of health care coverage services to providers and clients.

Target #1: Decrease average response time from receiving a claim to paying a claim. **Measure #1:** Average number of days per annum from receipt of claims to payment of claims.

Operation Performance Summary-Annual Average Days /Entry Date to Claims Paid Date

Year	Medicaid Claims	Avg Days	Days Changed
FY 2000	3,720,254	10	0
FY 2001	4,409,121	12	2
FY 2002	4,959,864	12	0
FY 2003	5,615,072	10	-2
FY 2004	6,690,344	10	0
FY 2005	7,903,523	13	3
FY 2006	7,721,709	12	-1
FY 2007	7,263,956	18	6

Note: Between FY02 and FY03 reports were based on six months of data. Since FY04 reports are based on annual data. Source: MARS MR-0-08-T. No national average available.

Analysis of results and challenges: Average days to pay between FY 2006 and FY 2007 increased from 12 days to 18 days.

Three new initiatives, two in the second half of FY 2006 and the other in first quarter 2007 may provide explanations for the increase of average days. The Personal Care Program instituted a prior authorization process during the third quarter 2006. As part of this new initiative, claims became subject to prior authorization editing. Additionally, regulatory changes for certain Durable Medical Equipment (DME) high-volume supplies occurred during the second half of FY 2006. This resulted in additional claims pending for evaluation and pricing. Lastly, during the first quarter 2007, several new home and community-based waiver program edits were initiated.

Adding to the hindrance, the Department of Health and Social Services' (HSS) contractor experienced a data entry backlog as they converted from outsourced data entry services to in-house data entry. As training is completed and staff becomes more proficient, holdups are improving for the second quarter of FY 2007.

All of the above would have had impact on processing time.

Target #2: Increase the percentage of adjudicated claims paid with no provider errors. **Measure #2:** Change in the percentage of adjudicated claims paid with no provider errors.

Error Distribution Analysis Change in the percentage of adjudicated claims paid with no provider errors

Year	Medicaid Claims Pd	% No Errors	% Change
FY 2000	3,076,978	72%	0
FY 2001	3,670,331	73%	1%
FY 2002	4,202,677	74%	1%
FY 2003	4,776,730	73%	-1%
FY 2004	5,106,692	76%	3%
FY 2005	6,150,027	72%	-4%
FY 2006	6,082,318	74%	2%
FY 2007	5,606,347	72%	-2%

- 1. Between FY01 and FY03 reports were based on six months of data. Since FY04 reports are based on annual data.
- 2. This measure was updated annually through FY 2005; beginning with FY 2006, it is being updated quarterly.
- 3. Source: MARS MR-0-11-T.

Analysis of results and challenges: Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. First Health, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

During FY2006, the Department of Health and Social Services (HSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, HSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice and therefore the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required HSS to deny pharmacy claims for Medicare-covered drugs for those recipients of both Medicaid and Medicare. Previously, Medicaid paid for this same population. This results in a significant denial of claims.

These major changes to the Pharmacy program were surely noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

Target #3: Reduce the rate of Medicaid payment errors.

Measure #3: Improper payment estimates as provided to Center for Medicare and Medicaid Services.

Analysis of results and challenges: The Improper Payments Information Act of 2002 (Public Law 107-300) requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments and report those estimates to the Congress, and if necessary, submit a report on actions the agency is taking to reduce erroneous payments. The effect of this rule is that states are now to be required to produce improper payment estimates for their Medicaid and SCHIP programs and to identify existing and emerging vulnerabilities.

The PERM program commenced nationally on July 1, 2005 with Phase I and one-third of the states participated. Alaska is a year 3 state and will be required to participate during calendar year 2007. There will be an impact on the resources in each division managing Medicaid Services to assist the PERM staff with access to policies, procedures and data. Division staff may be called upon to assist in the interpretation of medical records pertaining to claims associated with services that division manages. The PERM process includes expectations for corrective actions. Divisions will need resources to implement corrective actions resulting from PERM findings.

D1: Strategy - Continue to develop new Medicaid Management Information System (MMIS).

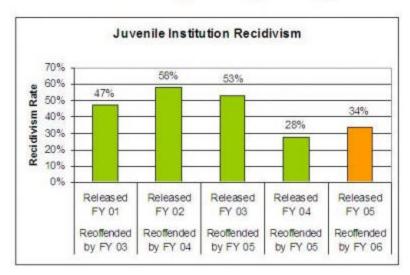
E: Result - Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.

Target #1: Reduce percentage of juveniles who reoffend following release from institutional treatment facilities to less than 33%.

Measure #1: Percentage change in reoffense rate following release from institutional treatment.

Facility	Number released in FY 05		Percentage of offenders who reoffended
Bethel Youth Facility	9	4	44%
Fairbanks Youth Facility	18	8	44%
Johnson Youth Center	10	3	30%
McLaughlin Youth Center	66	20	30%
Total	103	35	34%

Race	Number released in FY 05		of offenders who reoffended
Caucasian	39	12	31%
African American	4	1	25%
Native Alaskan/American Indian	37	16	43%
Asian	3	1	33%
Pacific Islander	1	0	0%
Multiple Races	18	5	28%
Other	1	0	0%
Total	103	35	34%



Analysis of results and challenges: The recidivism rate for juveniles released from Alaska's secure treatment institutions was increased slightly this year. The increase may not be significant; the small number of youth released from these institutions each year make it difficult to determine whether changes in the

recidivism rate from year to year are part of a trend or an anomaly. The change in recidivism rate for this population also may be due to the fact that, for the first time, this information was gathered and analyzed at the division director's office using the statewide Juvenile Offender Management Information System (JOMIS) instead of being submitted by individual facilities. Researching this measure at the statewide level ensured consistent application of the definitions that determine whether juveniles should be included in this measure, and whether or not they had committed reoffenses.

This measure examines recidivism only for youth who have been committed to and released from one of the division's four juvenile treatment facilities. These youth typically have the most intensive needs and are the states more chronic and serious juvenile offenders compared with youth who receive only probation supervision. Recidivism rates for these two populations are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

Recidivism among juveniles released in FY 04 and FY 05 is defined as reoffenses that occurred within a 12-month window. For youth released prior to these years, recidivism had to occur within 24 months. This change likely explains the demonstrated drop in recidivism for youth released in FY 04 and FY 05 compared with youth released in prior years; youth released later had a smaller window of time in which to reoffend. This change was made to better align Alaska's reporting of recidivism with the national norm of reporting recidivism on a 12-month basis. (Sixteen of the 32 states that track recidivism do so on a 12-month basis.) Among those states that measure recidivism based on a 12-month follow-up period, and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (8 states, including Alaska), the average recidivism rate was 33%. Alaska, at a 34% rate, closely reflects this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

Reoffenses, like the original offenses that brought the juveniles to the division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The division has adopted assessment tools, both for juveniles and the facilities that house them, that work with juveniles to address the root causes of their law-breaking behavior, and will continue to review institutional treatment components and research-based practices as it seeks to improve its outcomes for youths leaving institutions.

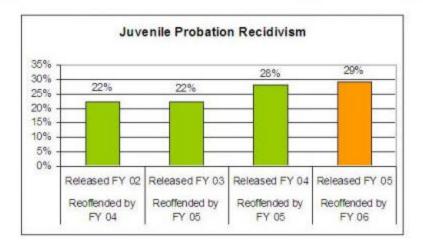
Note: Reoffenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's database and the Alaska Public Safety Information Network. Juveniles are included in this measure if the reason for their release from the treatment facility is marked in JOMIS as "Completion of Treatment," "Sentence Served," Court-Ordered Release," "Transfer to a Non-DJJ Facility," "Order Expired," or "Transfer (Transitional Services Step Down)." Reoffenses are defined as: any offenses that occurred within 12 months of release and that resulted in a new juvenile adjudication or adult conviction, or a probation violation resulting in a new institutionalization order, by August 1, 2007. Adjudications and convictions for motor vehicle, Fish and Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska also are excluded from analysis.

Target #2: Reduce percentage of juveniles who reoffend following completion of formal court-ordered probation supervision to less than 33%.

Measure #2: Percentage change in re-offense rate following completion of formal court-ordered probation supervision.

Region	Number of offenders released from formal probation in FY 05	Number of reoffenders 12 months after releas	Percentage of offenders who se reoffended
Anchorage	99	27	27%
Northern Region	107	34	32%
Southcentral Region	80	22	28%
Southeast Region	42	12	29%
Total	328	95	29%

Race	Number released from formal probation in FY 05	Number of Reoffenders 12 months after release	Percentage of offenders who reoffended
Asian	11	3	27%
African-American	13	4	31%
Multi-race	36	5	14%
Alaska Native/American Indian	130	47	36%
Pacific Islander	5	2	40%
Other	2	1	50%
Caucasian	131	33	25%
Total	328	95	29%



Analysis of results and challenges: The defined recidivism rate for this population was 29%, a small and likely insignificant increase compared with the previous year's rate.

FY 07 was the second year that recidivism was defined as a reoffense that occurred within 12 months from the time offenders were released from formal probation. In years prior to FY 06, reoffenses were counted if they occurred within 24 months of release from formal probation. The change to a 12-month window was made to better align Alaska with other states' definitions of recidivism. This measure also was changed to better correlate with the institutional recidivism measure (as well as national recidivism statistics) in that an offense needed to result in a new adjudication in the juvenile system or a conviction in the adult system to be counted as a reoffense (previously, only referrals to the juvenile system were counted as reoffenses). The increase in recidivism among the population of youth released from formal probation in FY 04 and FY 05 is likely due to the inclusion of offenses occurring within the adult system. Inclusion of adult offenses is a more accurate measure of the activity of offenders once they are released from juvenile probation.

This measure examines reoffense rates for juveniles who received probation supervision while either

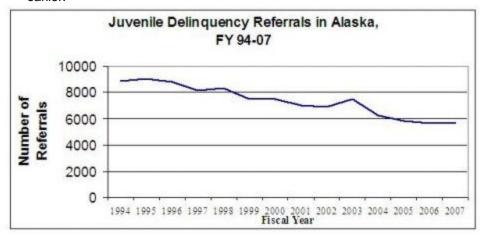
remaining at home or in a nonsecure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior than youth who have been institutionalized. (Recidivism rates for institutionalized youth are analyzed in a separate performance measure, above, and are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.)

Sixteen of the 32 states reported to track recidivism do so on a 12-month basis. Among those states that measure recidivism based on a 12-month follow-up period, and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (eight states), the average recidivism rate was 33%. Alaska, at a 29% rate for its probation population, compares favorably with this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

Reoffenses, like the original offenses that brought the juveniles to the Division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The Division has adopted a new risk and needs assessment tool to better work with juveniles to address the root causes of their law-breaking behavior, and will continue to review and incorporate research-based practices as it seeks to improve its outcomes for youth on probation supervision.

Note: Reoffenses for juveniles released from formal probation are determined by checking for entries in the Division's Juvenile Offender Management Information System and the Alaska Public Safety Information Network. This table reports the number of youth for whom court-ordered probation episodes closed during the fiscal year for one of the following reasons: Completed Successfully, Order Expired, Non-compliant Closed, Waived to Adult Status, Declared Incompetent, or Deceased. Youth whose formal probation ends because of Court Termination Resulting in a new Supervision, Modified, Revoked, or Supervision Transfer are not included. Youth also are not included who have been reassigned to a formal probation order (with or without custody) within seven days of release, as this typically reflects a modification of probation status or custodial placement rather than true completion of supervision. This analysis also excludes youth who were ordered to an Alaska treatment institution anytime prior to their supervision end date, as these youth are included in the analysis for our institutional recidivism performance measure, above, Adjudications and convictions for Motor Vehicle, Fish and Game, non-habitual violations of Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudications and convictions received outside Alaska are excluded from analysis. To be counted as recidivists, youth must have committed an offense within 12 months of their probation end date in FY 05, and the offense must have resulted in an adult conviction or new juvenile adjudication by August 1, 2007.

Target #3: Alaska's juvenile crime rate will be reduced by 5% over a two-year period.Measure #3: Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.



Target Fiscal Year	20	104	20	05	20	06	20	07
Number of Referrals per 100,000 population aged 10-17	6893		6512		6345		6490	
Comparison Year	2002	2003	2003	2004	2004	2005	2005	2006
Percentage Increase (or Decrease) between Target Year and Comparison Year	(10.5%)	(16.7%)	(21.3%)	(5.5%)	(8.0%)	(2.6%)	(0.3%)	2.3%

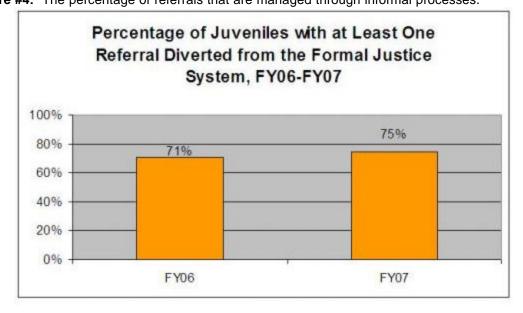
Region	Office	Juveniles	Percent of State	Referrals	Percent of State	Charges	Percent of State
Anch.	Anchorage	1,537	40%	2,200	39%	3,532	36%
NRO	Barrow	128	3%	230	4%	318	3%
	Bethel	202	5%	290	5%	602	5%
	Fairbanks	428	11%	592	10%	1026	1096
	Kotzebue	86	2%	136	2%	245	2%
	Nome	126	3%	242	4%	452	5%
	NRO Total	970	25%	1,490	26%	2,643	27%
SCRO	Dillingham	66	2%	91	2%	147	196
	Homer	45	1%	61	1%	82	1%
	Kenai	286	7%	384	7%	695	7%
	Kodiak	95	2%	160	3%	241	2%
	Mat-Su	368	9%	467	8%	900	9%
	Valdez	54	1%	81	1%	179	2%
	SCRO Total	914	24%	1244	22%	2244	23%

Analysis of results and challenges: The number of referrals and the percentage of these referrals per 100,000 juvenile population were virtually unchanged in FY07 compared with FY06, with a slight but insignificant increase in both measures noted. Definitive reasons for changes in referral levels are unknown, although possible causes could include changes in economic conditions, changes in prevention and intervention techniques, changes in law enforcement practices or resources, or a combination of some or all of these.

Note: Population data for youth aged 10-17 during the years 2003-2006 is provided by the Alaska Department of Labor and Workforce Development. The population estimate for the year 2007 was derived from the report Alaska Population Projections 2007-2030, published by the Alaska Department of Labor and Workforce Development (page 23). Juvenile referral data was extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database on August 10, 2007 and includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

Target #4: Divert at least 70% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses.

Measure #4: The percentage of referrals that are managed through informal processes.



Analysis of results and challenges: In FY 07 the proportion of juveniles with at least one referral (a report from law enforcement alleging a juvenile perpetrator) who were diverted from the formal court process remained high, at 75%. This means that 2,891 of the 3,876 juveniles referred in FY 07 had one of those cases managed through non-court adjustments, informal probation, referral to community panels such as youth court, or were dismissed. The percentage increased compared with FY 06 results, but because this is only the second time the Division has considered this measure, the improvement may be due to refinements in our record-keeping, data-gathering, and analysis.

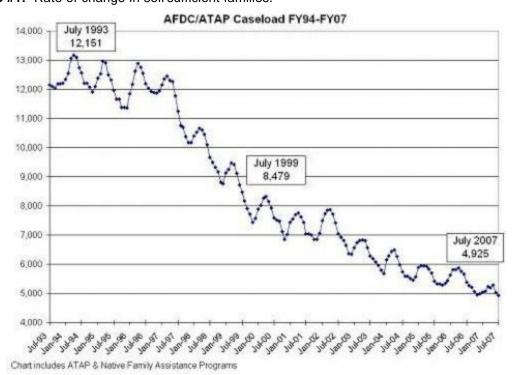
Diversion of youth from formal court processing serves a number of important, valuable purposes. It helps low-risk juveniles who are unlikely to re-offend avoid the stigma and needless harm that can result from delinquency adjudication. Diversion can provide opportunities for community partners and victims to take more active roles in handling low-risk juvenile offenders. Diversion processes reduce burdens on the court system, who otherwise would find it impossible to adjudicate every offender referred to them. Diversion also is considerably less expensive and faster than the formal adversarial process. Diversion processes reduce probation caseloads as well, enabling the division to better allocate resources and staff time to more serious offenders.

Note: For this measure, youth are considered to have been diverted away from the formal court system if the intake decision for their delinquency referrals resulted in at least one referral being adjusted, dismissed, placed on informal probation, or forwarded to a community justice panel such as youth court. Referrals that are screened and referred elsewhere, such as back to law enforcement for further information, and those that were still in process at the time this data was collected are excluded from consideration. This data is continually refined and corrected and numbers in future reports may change slightly.

E1: Strategy - Implement and review information from research-based assessment tools, and incorporate practices proven to reduce recidivism and criminal behavior among youth.

F: Result - Outcome Statement #6: Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10% annually. **Measure #1:** Rate of change in self-sufficient families.



Changes in Self Sufficiency

Changes ii	Shanges in Sen Suniciency				
Year	September	December	March	June	YTD
FY 2002	-16%	6%	4%	3%	-2%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2006	-6%	-3%	-4%	-1%	-2%
FY 2007	-2%	-8%	-10%	-10%	-7%
FY 2008	-7%	0	0	0	0
		0%	0%	0%	0%

^{*}YTD Total column represents the average annual monthly caseload rate change.

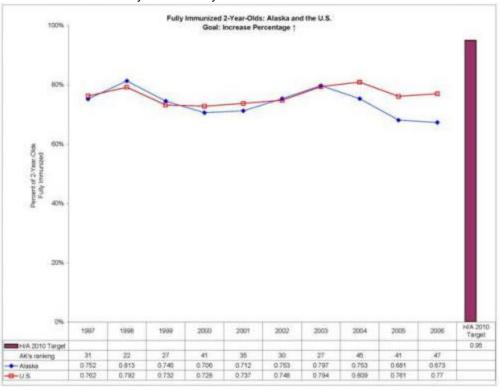
Analysis of results and challenges: As shown in the YTD Total column, FY2007 had a 7% decline in the number of families receiving Alaska Temporary Assistance Program benefits compared to FY2006. The other four columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

F1: Strategy - Use TANF high performance bonus funds for families approaching 60month time limit.

G: Result - Outcome Statement #7: Healthy people in healthy communities.

Target #1: 80% of all 2 year olds are fully immunized. **Measure #1:** % of all Alaskan 2 year olds fully immunized.



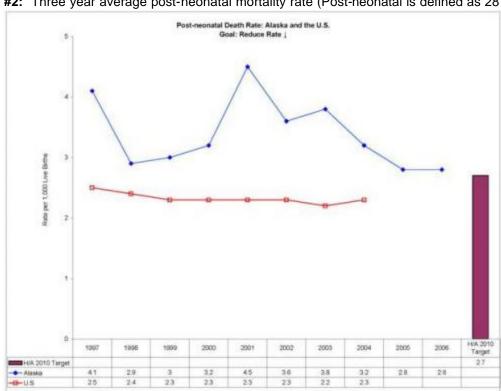
Vaccination Coverage Among Children 19-35 Months of Age, Alaska and US

Year	US %	Alaska %	
1999	73.2	74.5	27
2000	72.8	70.6	41
2001	73.7	71.2	35
2002	74.8	75.3	30
2003	79.4	79.7	27
2004	80.9	75.3	45
2005	76.1	68.1*	41
2006	77.0	67.3*	47

In 2005, CDC began using a new six-dose standard for its recommended basic immunization series.

Analysis of results and challenges: Chart Note: Source - National Immunization Survey, Centers for Disease Control and Prevention. Annual percentages are based on CDC recommendations at the time, which have changed over the years as vaccines have been added to the "basic immunization series."

* In 2005, the CDC increased its recommendation to a new, six-dose series of vaccinations. As a result, the national rate of fully immunized two year olds dropped considerably, as did Alaska's rate. These results continue to illustrate the need for renewed emphasis on the importance of timely immunizations for young children.



Target #2: Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010. **Measure #2:** Three year average post-neonatal mortality rate (Post-neonatal is defined as 28 days to 1 year).

Post-Neonatal Death Rate - AK and US

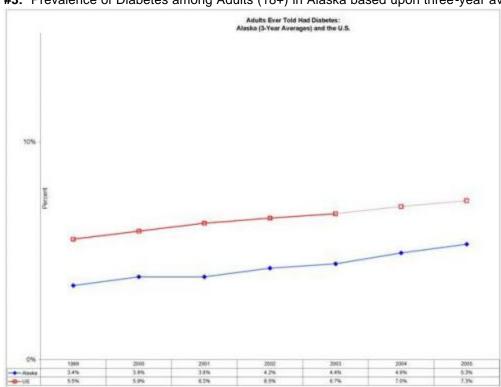
Year	Alaska	US
1999	3.0	2.3
2000	3.2	2.3
2001	4.5	2.3
2002	3.6	2.3
2003	3.8	2.2
2004	3.2	2.3
2005	2.8	N/A
2006	2.8	N/A

Note: The National Center for Health Statistics has not yet released US death rates for 2005 and 2006.

Analysis of results and challenges: Chart Note: Rate per 1,000 Live Births and reflects three-year rate, i.e. 2006 represents 2004-2006.

Post-neonatal mortality is more often caused by environmental conditions than problems with pregnancy and childbirth. Nationally, the leading causes of death during the post-neonatal period (28 through 364 days) during 2002 were Sudden Infant Death Syndrome (SIDS), birth defects, and unintentional injuries. The post-neonatal mortality rate in Alaska is higher than the national target of 1.5 per 1,000 live births (Healthy People 2010) and has remained relatively static over time. While not shown graphically, over the last decade Alaska Native infants were 2.3 times more likely to die during the post-neonatal period than Caucasian infants.

Work by DHSS is underway with the Indian Health Service on a rural initiative to prevent Sudden Infant Death Syndrome (SIDS). Also, cessation efforts involving tobacco, alcohol and other drugs are being targeted on the pre-conception and prenatal periods. Finally, work has begun with health providers and community partners to establish a model program of early prevention and chronic disease management for prenatal patients.



Target #3: Decrease diabetes in Alaskans.

Measure #3: Prevalence of Diabetes among Adults (18+) in Alaska based upon three-year averages.

Est. Annual Prevalence of Diabetes among Adults (18+) in Alaska Based upon Midpoints of Three-Year Averages

Year	Alaska	US
1999	3.4%	5.6%
2000	3.8%	6.1%
2001	3.8%	6.5%
2002	4.2%	6.7%
2003	4.4%	7.2%
2004	4.9%	7.0%
2005	5.3%	7.3%

Note: 2005 Alaska data is based on a 3-year average of 2004-2006.

Analysis of results and challenges: Data Source: BRFSS - Behavioral Risk Factor Surveillance System

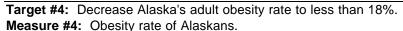
Diabetes is a chronic disease characterized by high levels of blood glucose. Type 2 diabetes accounts for 90 to 95 percent of all diagnosed cases and typically occurs in adults, but is increasingly being diagnosed in children and adolescents. Type 2 diabetes usually begins as insulin resistance, a condition in which the cells do not use insulin properly. Risk factors for Type 2 diabetes include older age (40-plus years), obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity.

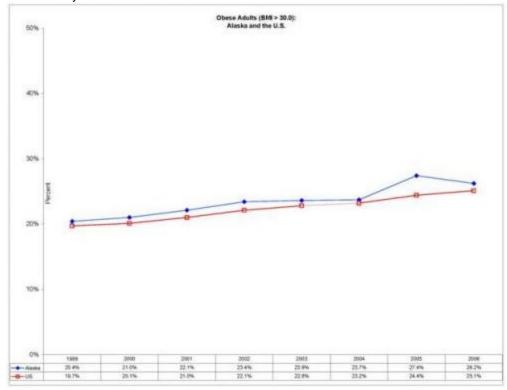
Diabetes is the leading cause of blindness and end-stage renal disease in adults. Diabetes increases the risk of heart disease, stroke, and many infectious diseases. Nerve damage from diabetes is the leading cause of lower extremity amputations. Diabetes prevalence increases with age, and the prevalence of diabetes in the United States is expected to increase as the population ages.

Over the past decade, an increasing number of Alaskan adults have reported being told by a health professional that they have diabetes. This number, plus the estimated 29% of all diabetes cases that go

undiagnosed, yields the best estimate of the true prevalence of diabetes in Alaska. One limitation of this estimate is that, with improving surveillance and detection, prevalence will continue to increase independent of any real increase in morbidity.

The department works to reduce the health burden and economic costs of diabetes in Alaska through an integrated program of prevention and disease management that supports our community partners. To slow or halt the upward trend of diabetes, a comprehensive approach is needed to make healthy behaviors the norm. The major risk factors contributing to chronic diseases are tobacco use, physical inactivity, unhealthy eating habits and resulting obesity. The department will address all of these factors by providing the knowledge and tools needed to make healthier choices, while also assuring that healthy behaviors are reinforced in schools, worksites and other community settings.





Prevalence of Obesity: Alaska & US

Year	Alaska	US
1999	20.4%	19.7%
2000	21.0%	20.1%
2001	22.1%	21%
2002	23.4%	22.1%
2003	23.6%	22.8%
2004	23.7%	23.2%
2005	27.4%	24.4%
2006	26.2%	25.1%

Analysis of results and challenges: Analysis of results and challenges: The trends in Alaska continue to show growing numbers of overweight and obese adults, with an obesity rate of 26.2% in 2006. By comparison, the Healthy Alaskans 2010 target for obesity is 18%.

Premature death and disability, increased heath care costs, and lost productivity are all associated with overweight and obesity. Unhealthy dietary habits combined with sedentary behavior are primary factors in

increasing body fat levels. Overweight and obesity are estimated to be responsible for approximately 300,000 deaths per year in the United States.

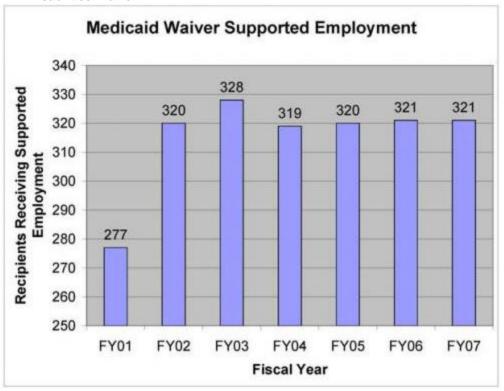
National studies show an association of overweight and obesity with certain types of cancers (endometrial, colon, post menopausal breast, and prostate), as well as heart disease, stroke, diabetes and arthritis. Overweight and obesity are directly associated with at least four of the top ten leading causes of death. Mortality due to unintentional injury, suicide, chronic obstructive pulmonary disease (COPD), pneumonia, and liver disease may also be influenced by obesity to some extent.

Through educational, programmatic, policy and environmental strategies, the department works to reduce the percentage of Alaskans classified as overweight, obese or at-risk for being overweight, and to promote healthy food choices and exercise. A comprehensive approach is needed to reduce the trend of increasing obesity in Alaska. Along with tobacco use, physical inactivity and unhealthy eating habits, obesity contributes greatly to the prevalence of chronic disease. The department is working to address all of these factors by giving individuals the knowledge and tools they need to make healthier choices, targeting the promotion of healthy behaviors in communities - the workplace, schools and other settings.

G1: Strategy - Strengthen public health in strategic areas.

H: Result - Outcome Statement #8: Senior and physically and/or developmentally disabled Alaskans live independently as long as possible.

Target #1: Increase the number of DD waiver recipients receiving Supported Employment Services. **Measure #1:** % change of beneficiaries receiving supported employment services under Developmental Disabilities Waiver.



% Change in Recipients Receiving Supported Employment

Year	% Change
FY 2002	15.5%
FY 2003	2.5%
FY 2004	-2.7%
FY 2005	0.3%
FY 2006	0.3%
FY 2007	0.0%

Analysis of results and challenges: Supported Employment Services is one of the best resources available to developmentally disabled beneficiaries to help them live independently by providing them with the opportunity to work. The Division of Senior and Disabilities Services has determined that the reason the number of DD waiver beneficiaries receiving supported employment has reached a plateau in recent years is because only the highest-functioning clients without behavioral issues can be easily employed. In FY07 and beyond, the division will be working with the Governor's Council on Disabilities and Special Education to increase participation in supported employment as outlined in the Alaska Works Initiative 2006-2010 Strategic Plan.

H1: Strategy - Promote independent living and provide preadmission screening to nursing homes.

I: Result - Outcome Statement #9: The efficient and effective delivery of administrative services.

Target #1: Reduce the average response time for complaints/inquiries to 14 days. **Measure #1:** Department Inquiry/Complaint "HSS Track" log response times.

of Inquiries/Complaints

Year	Opened	Closed	Avg Days to Close
FY 2005	552	503	15.18
FY 2006	1590	1408	25.78
FY 2007	1495	1224	24.52

Analysis of results and challenges: The response log "HSS Track" includes all inquiries or complaints that are received by the DHSS Commissioner's Office (i.e., public or legislative complaints, legislative questions, press inquires, etc.).

The increase in the inquiries/complaints opened in FY06 is attributed to the fact that in FY05 only a limited number of sections in the department were utilizing the log. In FY06, the Office of Children's Services was added to the HSS Track. This greatly increased the number and complexity involved to close out inquiries.

The response log "HSS Track" will be monitored by the Commissioner's Office.

Target #2: Reduce by 5% per year processing time for key indicators.

Measure #2: Track number of days it takes to process: Purchase Requisitions; Operating Grant Awards; Processing Time for Payments; Capital Grant Awards; and Legislative inquiries.

-	Fiscal Year 2006	
	#Processed	Days to Process
Purchase Requisitions	507	7.00
Operating Grant Awards	610	19.12
DHSS Invoices	158,281	9.33
Capital Grant Awards	93	3.36
Legislative Logs	172	3.52

	Fiscal Year 2007	
	#Processed	Days to Process
Purchase Requisitions	459	5.80
Operating Grant Awards	628	20.97
DHSS Invoices	94,050	9.17
Capital Grant Awards	101	1.50
Legislative Logs	191	4.16

Analysis of results and challenges: This is a new indicator with new data for FY2006. The data will develop a baseline for future comparisons.

In FY07, the number of requests increased in several of the categories, resulting in an overall increase to the average response time. Although there was increased processing time and increased number of requests, the sections remained under the standard response time in FY07.

Prioritization of Agency Programs

(Statutory Reference AS 37.07.050(a)(13))

Prioritization of program resources is based on four key factors:

- Relevance of the activity to the department's mission.
- The Department has sole responsibility for providing service.
- Protection of vulnerable Alaskans.
- Provision of direct services to clients.
- 1. Alaska Psychiatric Institute
- GRA/Temporary Assisted Living (Sr. & Disabilities Svcs)
- 3. Epidemiology
- 4. Alaska Temporary Assistance Program (ATAP)
- 5. Tribal Assistance Programs
- 6. Pioneer Homes
- 7. HCS Medicaid Services

- 51. Youth Courts
- 52. Certification and Licensing
- 53. State Medical Examiner
- 54. Senior Residential Services
- 55. General Relief Assistance (Public Assistance)
- 56. Community Health Grants
- 57. Community Action Prevention & Intervention Grants
- 58. Designated Evaluation and Treatment

FY2009 Governor
Department of Health and Social Services

Released December 10th

- 8. Senior and Disabilities Medicaid Services
- 9. Behavioral Health Medicaid Services
- 10. Children's Medicaid Services
- 11. Senior Benefits Program
- 12. Probation Services
- 13. Adult Public Assistance
- 14. Community Developmental Disabilities Grants
- 15. Foster Care Base Rate
- 16. Foster Care Augmented Rate
- 17. Foster Care Special Need
- 18. McLaughlin Youth Center
- 19. Delinquency Prevention
- 20. Fairbanks Youth Facility
- 21. Johnson Youth Center
- 22. Bethel Youth Facility
- 23. Nome Youth Facility
- 24. Ketchikan Regional Youth Facility
- 25. Mat-Su Youth Facility
- 26. Kenai Peninsula Youth Facility
- 27. Public Health Laboratories
- 28. Residential Child Care
- 29. Psychiatric Emergency Services
- 30. Behavioral Health Grants
- 31. Rural Services and Suicide Prevention
- 32. Services for Severely Emotionally Disturbed Youth
- 33. AK Fetal Alcohol Syndrome Program
- 34. Services to the Seriously Mentally III
- 35. Catastrophic and Chronic Illness Assistance
- 36. Nursing
- 37. Front Line Social Workers
- 38. Adult Preventative Dental Medicaid Svcs
- 39. Subsidized Adoptions & Guardianship
- 40. Child Care Benefits
- 41. Work Services
- 42. Chronic Disease Prevention/Health Promotion
- 43. Energy Assistance Program
- 44. Bureau of Vital Statistics
- 45. Emergency Medical Services Grants
- 46. Human Services Community Matching Grant
- 47. Senior Community Based Grants
- 48. Women, Infants and Children
- 49. Family Preservation
- 50. Infant Learning Program Grants

- 59. Commissioner's Office
- 60. Administrative Support Services
- 61. Facilities Management
- 62. Quality Assurance and Audit
- 63. Health Stratetgies Council
- 64. Information Technology Services
- 65. Public Affairs
- 66. Rate Review
- 67. Quality Control (Public Assistance)
- 68. Fraud Investigation
- 69. Hearings and Appeals
- 70. Office/Faith-Based and Community Initiatives
- 71. Health Planning & Infrastructure
- 72. Facilities Maintenance
- 73. Pioneers Homes Facilities Maintenance
- 74. Children's Services Training
- 75. Public Assistance Field Services
- 76. Child Protection Legal Svcs
- 77. Injury Prev/Emerg Med Svcs
- 78. Preparedness Program
- 79. Tobacco Prevention and Control
- 80. Assessment and Planning (Medicaid)
- 81. Women, Children & Family Health
- 82. Medicaid School Based Administrative Claims
- 83. HSS State Facilities Rent
- 84. Alaskan Pioneer Homes Management
- 85. Behavioral Health Administration
- 86. Children's Services Management
- 87. Medical Assistance Administration
- 88. Public Assistance Administration
- 89. Public Health Administrative Services
- 90. Senior and Disabilities Services Administration
- 91. Permanent Fund Dividend Hold Harmless
- 92. Council on Faith Based & Community Initiatives
- 93. Children's Trust Programs
- 94. Alcohol Safety Action Program (ASAP)
- 95. Alaska Mental Health/Alcohol & Drug Abuse Brds
- 96. Commission on Aging
- 97. Governor's Council on Disabilities
- 98. Pioneers Homes Advisory Board
- 99. Suicide Prevention Council

Alaska Pioneer Homes Results Delivery Unit

Contribution to Department's Mission

Provide the highest quality of life in a safe home environment for older Alaskans and veterans.

Core Services

Provide residential assisted living services.

End Result	Strategies to Achieve End Result
A: Outcome statement - Eligible Alaskans and Veterans will live in a safe environment.	A1: 1) Improve the medication dispensing and administration system.
Target #1: Reduce resident serious injury rate. Measure #1: Hold constant, below the national level, the number of medication errors and falls that result in serious injury.	Target #1: Less than one percent medication error rate, which is one-half the low end of the national standard range. Measure #1: Percent of medication administration errors.
	A2: 2) Reduce the number of residents' serious injuries from falls.
	Target #1: Less than two percent injury rate, which is the low end of the National Safety Council's range of two to six percent.
	Measure #1: Percent of Pioneer Homes serious injuries from falls.

FY2009 Resources Allocated to Achieve Results			
	Personnel:		
FY2009 Results Delivery Unit Budget: \$53,951,700	Full time	557	
	Part time	49	
	Total	606	

Performance Measure Detail

A: Result - Outcome statement - Eligible Alaskans and Veterans will live in a safe environment.

Target #1: Reduce resident serious injury rate.

Measure #1: Hold constant, below the national level, the number of medication errors and falls that result in serious injury.

Analysis of results and challenges: Increasing age and acuity levels of Pioneer Homes residents creates a challenge in reducing adverse events that result in serious injury. By properly utilizing the strength of trending

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and tracking information available in the division's risk analysis program, the Homes are able to identify times, places, individual staff and conditions that hold inherent risk. Action plans to address risk help the Homes prevent errors, reduce the number of serious injury events, and reduce the severity of injury.

See Alaska Pioneer Homes Division Level Strategy A1 and A2: Target 1: Measure 1 for explanation and tables.

A1: Strategy - 1) Improve the medication dispensing and administration system.

Target #1: Less than one percent medication error rate, which is one-half the low end of the national standard range.

Measure #1: Percent of medication administration errors.

Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD
2002	0.07%	0.08%	0.04%	0.05%	0.06%
2003	0.10%	0.11%	0.09%	0.15%	0.11%
2004	0.07%	0.11%	0.06%	0.07%	0.08%
2005	0.08%	0.09%	0.09%	0.14%	0.10%
2006	0.19%	0.15%	0.16%	0.12%	0.17%
2007	0.19%	0.22%	0.15%	0.14%	0.18%
2008	0.16%	0	0	0	0
		0%	0%	0%	0%

The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications taken by all Pioneer Home residents in the same quarter.

Analysis of results and challenges: The Centers for Medicare and Medicaid Services, which licenses nursing facilities throughout the United States, considers a five percent medication error rate acceptable.

The Pioneer Home system collects medication information at the individual Pioneer Home level and aggregates the numbers for reporting at the division level. In 2006, Pioneer Home staff administered an average of 434,464 individual medications each quarter.

All care processes are vulnerable to error, yet several studies have found that medication-related activities are the most frequent type of adverse event. Medication administration errors are the traditional focus of incident reporting programs because they are often the types of events that identify a failure in other processes in the system. A wrong medication may be administered because it was prescribed, transcribed, or dispensed incorrectly. The division uses a system-wide risk reporting program that tracks medication errors, and allows the collected data to be reported and trended for use in identifying risks. Trending the cause of the error tends to provide the most useful information in designing strategies for preventing future errors.

A2: Strategy - 2) Reduce the number of residents' serious injuries from falls.

Target #1: Less than two percent injury rate, which is the low end of the National Safety Council's range of two to six percent.

Measure #1: Percent of Pioneer Homes serious injuries from falls.

Sentinel Event injury rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD
2002	2.9%	0.7%	0.0%	0.37%	0.99%
2003	1.1%	0.04%	1.79%	1.5%	1.1%
2004	1.96%	1.26%	0.97%	1.47%	1.45%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2007	3.5%	1.2%	2.0%	2.1%	2.2%
2008	1.5%	0	0	0	1.5
		0%	0%	0%	0%

The Sentinel Event Injury rate reports the percentage of falls that result in a major injury. The rate is calculated by dividing the number of Sentinel Event injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: Seventy-five percent of elderly deaths result from falls.

Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problems are even more disturbing. The event is called sentinel because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older, fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to \$32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

The average age of Pioneer Homes residents is 84.9, putting them in the highest risk category for suffering a serious injury from a fall that could lead to death.

The Pioneer Homes respond to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

The analysis of the spike in sentinel event injuries between FY04 and FY05 does not indicate one root cause. There were, however, seven deaths associated with falls in FY05*. Of the total, six of the seven falls occurred when the resident was alone so they are categorized as unwitnessed. It is difficult to recreate the events leading up to an unwitnessed fall, especially if the fall involves a resident who suffers from dementia and is unable to articulate what occurred. Most of these falls are reported as "found on floor" and the sequence of events leading up to the fall reconstructed by staff depending on the time of day with some supposition on the activity the resident was attempting.

Because such a significant number of the witnessed falls are less severe than unwitnessed falls, the division built a case for increased staffing with the intention of reducing the number of falls that are unwitnessed. Three new positions were funded in FY06 and the table below shows a two percent decrease in the overall percentage of unwitnessed falls.

Unwitnessed Fall Rate

FY05 81% FY06 79%

^{*}Any death within 45 days of a sentinel event is associated with that event.

Behavioral Health Results Delivery Unit

Contribution to Department's Mission

The mission of the Division of Behavioral Health is to provide an integrated behavioral health system.

Core Services

The Division of Behavioral Health was created in 2003 by combining the mental health portion of the Division of Mental Health and Developmental Disabilities, the Division of Alcoholism and Drug Abuse, and the Office of Fetal Alcohol Syndrome. Its primary function is to provide treatment and prevention services for Alaskans with substance use disorders, mental illness, or a combination of both. There are also special sections devoted to behavioral health problems caused by traumatic brain injury and fetal alcohol spectrum disorders.

This RDU provides the overall administrative and organizational structure to support treatment and prevention services for substance abuse, mental illness and those at risk for these conditions. RDU functions include service system planning and policy development, programmatic oversight of behavioral health service, general administration, budget development and fiscal management, and operation of the Alaska Automated Information Management System (AKAIMS). The leadership in this RDU works closely with the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Trust Authority on policy development, planning and implementing services and supports for people who experience mental illness, substance abuse disorders, or both.

This RDU also provides centralized support for the Alaska Psychiatric Institute (API). API is located in Anchorage, and is the only publicly funded facility providing high level inpatient psychiatric care to the people of Alaska. These services are available when no other service is adequate to meet the needs of a severely ill individual or individual in crisis. It is a seven-day-a-week, 24-hour-a-day treatment facility. Clients are admitted either voluntarily or involuntarily through a Peace Officer Application or Ex Parte Commitment. API provides diagnosis, evaluation and treatment services in accordance with its statutory mandates and the strict health care industry standards and requirements set by the Joint Commission on Accreditation of Healthcare Organizations, Centers for Medicare and Medicaid Services, and the State of Alaska's Certification and Licensing section. API provides outreach, consultation, and training to mental health service providers, community mental health centers, and Pioneer Homes. In addition, API serves the entire Alaska community mental health system, including coordinating the transition of patients between inpatient and outpatient care, when appropriate.

End Result	Strategies to Achieve End Result
A: Outcome #1: Improve and enhance the quality of life for Alaskans with a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance abuse disorder.	A1: Strategy #1A: Improve and enhance the quality of life of children with a SED by implementing the Bring the Kids Home Program.
<u>Target #1:</u> 75% of individuals will report improvement in one or more of the following life domains: productive activity/employment, housing situation, health status, economic security, education attained.	Target #1: Reduce the number of kids in out-of-state placement by 25% annually over the next four years. Measure #1: Change in percent of children reported in out-of-state care from Medicaid MMIS.
Measure #1: Outcomes data as reported through the use of the Client Status Review Form as part of the Federal Government Performance and Results Act.	A2: Strategy #1B: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder by implementing the DH&SS Tribal Agenda.
	Target #1: Increase the number of tribal entities providing behavioral health services to Alaska Natives by 10% annually for each of the next four years.

Results Delivery Unit — Behavioral Healt
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Measure #1: Number of tribal entities providing behavioral health services directly or contracting with non-tribal providers for those services.

A3: Strategy #1C: Improve and enhance the quality of life of Alaskans with a SED. SMI and/or a substance abuse disorder through the development of a comprehensive, integrated Behavioral Health Service System.

Target #1: A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% improvement in service outcomes and consumer satisfaction.

Measure #1: Treatment satisfaction data from Behavioral Health Consumer Survey (BHCS; formerly called the Mental Health Statistics Improvement Program Consumer Survey, or MHSIP).

FY2009 Resources Allocated to Achieve Results			
FY2009 Results Delivery Unit Budget: \$293,872,600	Personnel: Full time	305	
, and a second of the second o	Part time	15	
	Total	320	

Performance Measure Detail

A: Result - Outcome #1: Improve and enhance the quality of life for Alaskans with a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance abuse disorder.

Target #1: 75% of individuals will report improvement in one or more of the following life domains: productive activity/employment, housing situation, health status, economic security, education attained.

Measure #1: Outcomes data as reported through the use of the Client Status Review Form as part of the Federal Government Performance and Results Act.

Analysis of results and challenges: The ability to determine treatment outcomes for clients of our mental health and substance abuse services is a relatively new and exceptionally useful tool. Not long ago, "is he still sober?" or "is she taking her meds?" were the only measures of success that behavioral health programs used: crude measures at best, and misleading at worst. Just as mental illness and substance abuse affects all areas of a person's life, so does recovery affect more than just a single variable. Therefore, clients of our programs are asked questions at entry, discharge, and at various points post-discharge, concerning a variety of "life domains." By comparing these responses, we are offered a picture of change in a person's life, regarding productivity (jobs, homemaking, student activity, subsistence activity, etc.), physical health, mental/emotional health, suicidality, social and family supports, safety, spirituality, finances, and housing.

A1: Strategy - Strategy #1A: Improve and enhance the quality of life of children with a SED by implementing the Bring the Kids Home Program.

Target #1: Reduce the number of kids in out-of-state placement by 25% annually over the next four years. **Measure #1:** Change in percent of children reported in out-of-state care from Medicaid MMIS.

Analysis of results and challenges: This measure is reported at the department level.

A2: Strategy - Strategy #1B: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder by implementing the DH&SS Tribal Agenda.

Target #1: Increase the number of tribal entities providing behavioral health services to Alaska Natives by 10% annually for each of the next four years.

Measure #1: Number of tribal entities providing behavioral health services directly or contracting with non-tribal providers for those services.

of Tribal Entities

Year	# Providing Service
FY 2004	4
FY 2005	8
FY 2006	14

Analysis of results and challenges: During SFY 2004, there were four tribal entities providing and billing for behavioral health services. During SFY 2005 the number of tribal entities providing and billing for behavioral health services increased to eight. These eight were: Bristol Bay Area Health Corporation, Copper River Native Association, Kenaitze Indian Tribe, Maniilaq Association, Norton Sound Health Corporation, Southcentral Foundation, Tanana Chiefs Conference, Yukon-Kuskokwim Health Corporation.

In 2006, fourteen tribal behavioral health grantees were enrolled as either a Community Mental Health Clinic and/or a substance abuse agency, and were enrolled to bill for Medicaid services. These were: Bristol Bay Area Health Corporation, Cook Inlet Tribal Council, Copper River Native Association, Eastern Aleutian Tribes, Fairbanks Native Association, Hoonah Indian Association, Kenaitze Indian Tribe, Ketchikan Indian Corporation, Maniilaq Association, Norton Sound Health Corporation, Southcentral Foundation, Southeast Regional Health Consortium, Tanana Chiefs Conference, and Yukon-Kuskokwim Health Corporation. Two other tribal entities, Aleutian Pribilof Island Association and Illiuliuk Family and Health, are enrolled, but have not yet billed.

A3: Strategy - Strategy #1C: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder through the development of a comprehensive, integrated Behavioral Health Service System.

Target #1: A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% improvement in service outcomes and consumer satisfaction.

Measure #1: Treatment satisfaction data from Behavioral Health Consumer Survey (BHCS; formerly called the Mental Health Statistics Improvement Program Consumer Survey, or MHSIP).

Percentage of	BHCS Re	spondents	Satisfied v	vith Servi	ices
Table 1.					
Adults DOMAIN	FY04	FY05	FY06	FY07	% increased between FY2004 and FY 2007
Participation in Treatment Planning	67%	71%	70%	70%	2%
Quality and Appropriateness	69%	77%	82%	80%	16%
Positive Outcomes of Services	55%	61%	73%	69%	26%
Access to Services	68%	70%	74%	75%	10%
General Satisfaction	77%	82%	82%	82%	6%
Percentage increase column calculated Table 2. Families with Children	as follows	: (FY07-F	Y04)/FY0	4.	
DOMAIN		FY05	FY06	FY07	% change between FY2004 and FY 2007
Access to Services		71%	72%	72%	1%
Satisfaction with Services		68%	74%	69%	2%
Participation in Treatment		84%	81%	82%	-2%
Cultural Sensitivity		87%	86%	85%	-2%
Positive Outcomes of Services		58%	64%	65%	12%
FY06 and FY07: Both Substance abustance abustance increase column calkalated Family with Children surveys do not hable 3. Youth DOMAIN	as follows	: (FY07-F	Y05)/FY05	5.	
AND					FY2004 and FY 2007
Access to Services		70%	65%	55%	-21%
Satisfaction with Services		77%	74%	69%	-10%
Participation in Treatment		68%	67%	65%	- 4%
Cultural Sensitivity		84%	86%	74%	-12%
Positive Outcomes of Services		73%	64%	70%	- 4%
FY06 and FY07: Both Substance abus Percentage increase column calculated Youth surveys do not have sufficient r	as follows	: (FY07-F	Y05)/FY05	5,	85

Analysis of results and challenges: The Behavioral Health Consumer Survey (BHCS) is one of several instruments used by the division to measure clients' level of satisfaction with behavioral health services. The survey is mailed or given to consumers and returned by them directly to the Division of Behavioral Health for processing.

This Performance Improvement Process improves survey validity each year. Early in the implementation of the BHCS, several factors greatly impacted the project: implementation was disrupted during the integration of the two divisions (Mental Health and Alcoholism and Drug Abuse); and there was inconsistent incorporation into business practices of behavioral health service providers. As a result the validity of measures in FY04 and FY05 is questionable due to the poor response rates.

For FY08, the following changes have been implemented as part of the improvement process: the division has improved oversight of the implementation of the consumer survey and developed a formal procedure to establish consistent implementation (timelines and methods) of the survey. These changes in the consumer survey process will result in a continued improvement in the sampling size and validity of survey findings.

Clearly, adult clients of our programs have become more satisfied over the last several years, while children

Results Delivery Unit -	— Behavioral Health
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and their families are less satisfied with certain aspects of treatment. The division is exploring these results with our providers and consumers in order to increase their levels of satisfaction and the positive outcomes of treatment.

Children's Services Results Delivery Unit

Contribution to Department's Mission

The mission of the Office of Children's Services is to promote stronger families, safer children.

Core Services

- Investigate protective service reports and ensure services to children and their families when necessary.
- Develop permanency plans for children in out-of-home care.
- Facilitate early intervention and treatment services.
- Prevent and remedy child abuse and neglect.

The Office of Children's Services (OCS) provides a range of services and support systems to prevent and remedy child abuse and neglect. These include child abuse and neglect prevention services, child protective services, foster care, residential care, family support and preservation services, adoption and guardianship, and permanency planning.

The Children's Services Management component delivers comprehensive program, managerial and financial support to the division's child protection services, family preservation services, and prevention services. This component has four primary units: the Director's Office, Resource Family Section, Service Array Section, the Program Eligibility Unit and Tribal IV-E Program Unit. This component also provides support services to the Online Resources for the Children of Alaska (ORCA) case management and financial/provider payment information management system. Other administrative functions provided for the OCS are located in Finance and Management Services under the department's Office of the Commissioner.

The Children's Services Training component provides education and training for OCS child protection social workers, licensing workers, supervisors, and managers to enhance their knowledge of child protection, abuse, and neglect. Required training increases employees' assessment skills in working with children and their families, and strengthens their ability to assess child safety and evaluate options to protect children when it has been determined that they would be unsafe remaining in their homes. Further, ongoing training allows workers to better ascertain the best interests of children as OCS pursues permanency for children who have been placed outside of their homes.

The Front Line Social Worker component delivers services to carry out the legal mandates of the department to prevent and remedy physical abuse, sexual abuse, neglect, mental injury, and the exploitation of children. For child protective services, primary activities include investigation of protective services reports; crisis intervention; assessment of the risk of future harm in the absence of intervention; family strength and needs assessment; and case planning. Additional functions include ongoing assessment toward achieving case plan goals, initiation of legal action to protect children, monitoring implementation of treatment plans, and the coordination services needed to reunify children with their families. Services of the Front Line Social Workers component also include arranging out-of-home care, when appropriate and necessary, in the least restrictive setting; and facilitating an alternative permanent home for children when their return to their home of origin is not possible.

The Family Preservation component awards grants statewide to non-profit agencies to provide services that keep children safe in their own homes; and to strengthen and support adoptive, foster, and extended families. Grantees provide family preservation services that help children at risk of foster care placement remain safely with their families, ensure after care once a child has been returned from foster care, and respite care to provide child care relief to families where a child is at risk of being abused or neglected.

Independent Living services support education, vocational training and life skills of youth in foster care as they enter early adulthood. These youths, 16 years and older, frequently lack the family or financial support and guidance

needed to gain self-sufficiency as they enter adulthood. Services provided to help these youths gain self-sufficiency include life skills assessments; transition learning plans; exit plans that identify a youth's goals for education, employment, housing, health care, mental health care, and family/community connections; financial assistance, and identification of additional resources the youth may require.

OCS's Foster Care Base Rate, Foster Care Augmented Rate and Foster Care Special Needs programs enable the state to find temporary homes for children who have been abused or neglected and cannot remain in their own homes. The OCS supports these foster care placements with services that meet both the needs of children in state custody and the department's statutory mandate to care for them. The Foster Care Base Rate program reimburses foster care providers for the basic ongoing costs of raising a child. The Augmented Foster Care Rate benefit covers extraordinary costs and higher levels of supervision not otherwise covered with base rate benefits. Foster Care Special Needs reimbursements are for pre-approved "one time" or "irregular" expenditures that are not covered through the Foster Care Base Rate program and that have been assessed on an as-needed basis.

OCS administers the Tribal Title IV-E Reimbursement Program. OCS, through agreements with Alaskan Tribes and Tribal Organizations, passes through approximately \$1.5 million of Title IV-E federal funds annually. In conjunction with OCS, Tribal staff provides child welfare services to Alaskan Native children in out-of-home placement and children at risk of out-of-home placement. Tribal organizations work closely with OCS to provide the federal government with the required, substantial documentation for IV-E determinations.

The Subsidized Adoption & Guardianship component furnishes permanent adoptive or guardianship homes and subsidies for children with special needs that are in custody of the state. These children would likely not be adopted without a subsidy because of their documented special needs. The program has been successful due to an increased emphasis on permanency planning and the commitment to move children from foster care to a permanent placement in as safe and as timely a manner as possible.

Residential Child Care facilities provide high quality, time-limited residential treatment services for abused, neglected, and delinquent children. These facilities deliver 24-hour care for children who are unable to remain in their own home or who need more structure and treatment than foster care provides. The OCS facilitates levels of residential treatment that include emergency stabilization and assessment, intensive residential treatment, residential diagnostic treatment and residential psychiatric treatment.

The Infant Learning Program ensures that young children who may have disabilities or developmental delays receive an evaluation to identify the potential need for early intervention services. Comprehensive, coordinated, home-based early intervention services include individualized family service plans outlining goals for the family and the child; child development information; home visits; physical, occupational, or speech therapy; specialized equipment; and/or referrals to other needed services.

The Early Childhood Comprehensive Systems Project is a federally funded project that facilitates planning and implementation of strategies in the areas of access to home medical care, family support and parent education, early care and education, and social-emotional development of young children.

The Strengthening Families Initiative (SFI) is a child abuse prevention effort supported by the Doris Duke Foundation that targets children in early care and education programs (child care centers and Headstart) between the ages of birth through five years. The SFI works to develop the protective skills of families through these settings and by offering supportive services to parents.

The Alaska Children's Trust program generates funds and commits resources to community-initiated projects that strengthen families and prevent child abuse and neglect. The Alaska Children's Trust awards grants from the net income of the Trust Fund to community-initiated projects on a competitive basis, monitors the approved grant projects for compliance and effectiveness, and submits to the Governor a report describing the services provided and the annual level of income and expense for the Alaska Children's Trust. The Trust solicits contributions through fundraising activities, gifts and bequests and applies for private and federal grants consistent with the purpose of the trust, to increase the value of the fund.

The Child Protection Legal Services component provides a small portion of OCS costs for services purchased from the Department of Law to support legal requirements from the point when a child is taken into custody through mandatory, periodic court reviews, and to permanency if all efforts to reunite a child with his or her family are unsuccessful. This particular component addresses the funding needed when a child cannot be reunified with his or her family and the child's best interests are supported through adoption.

End Result	Strategies to Achieve End Result
A: To prevent children from abuse and neglect. Target #1: Increase the number of Early Intervention/Infant Learning Program screenings for children age 0-3 to meet federal requirements. Measure #1: The number of children age 0-3 screened annually.	A1: Improve the referral process from Children's Protective Services to Early Intervention/Infant Learning Program services. Target #1: Increase the percentage of child protection services referrals provided to children ages 0-3 and attain federal compliance. Measure #1: Change in the percentage of completed referrals. A2: To reunify children in out-of-home placements with parents or caretakers as soon as it is possible. Target #1: Increase the rate of children reunified with their parents or caretakers within 12 months of removal. Measure #1: The percent of children reunified with
	parents or caretakers at the time of discharge from foster care in less than 12 months from the last removal.
End Result	Strategies to Achieve End Result
B: Safe and timely adoptions. Target #1: Increase the annual number of completed adoptions. Measure #1: Number of children placed in adoptive homes annually.	B1: Promote the use of adoption exchanges to recruit adoptive homes. Target #1: Increase recruitment of resource family homes. Measure #1: Number of resource family homes recruited annually. B2: Promote the adoption of older youth ages 12 - 18. Target #1: Increase the number of adoptions for youth age 12-18. Measure #1: The annual number of youth age 12-18 who are adopted.

FY2009 Resources Allocated to Achieve Results		
FY2009 Results Delivery Unit Budget: \$132,990,900	Personnel: Full time	475
	Part time	2
	Total	477

Performance Measure Detail

A: Result - To prevent children from abuse and neglect.

Target #1: Increase the number of Early Intervention/Infant Learning Program screenings for children age 0-3

to meet federal requirements.

Measure #1: The number of children age 0-3 screened annually.

Year	No. of Screenings	Target
2003	113	800
2004	200	800
2005	225	800
2006	278	800
2007	352	800

2007 data represents ONLY the first 3 quarters of FY 2007, which already exceed prior year screening numbers. OCS is awaiting 4th data.

Analysis of results and challenges: The Early Intervention/Infant Learning program (EI/ILP) goal is to have every child under the age of three with a substantiated protective services report screened and thus achieve federal compliance within three years. Currently EI/ILP screens only 40 percent of the required screenings under the Child Abuse Prevention and Treatment Act.

In 2003 U.S. Congress passed the Strengthening Families Bill requiring all children birth through three years of age who have been abused or neglected to be referred to the Early Intervention/Infant Learning (EI/ILP) program. By referring all 0-3 year old children who have a substantiated finding of abuse or neglect, the EI/ILP program can conduct an initial screening to identify speech and language delays, cognitive and motor delays and social and emotional delays and then connect families to any needed services. By linking families with services aimed at remedying identified needs of very young children, further abuse and neglect can be negated as associated risk factors are alleviated. While called prevention services, abuse or neglect has already occurred, and by providing this screening and subsequent services, the likelihood of repeat maltreatment is reduced.

The program, as the number of screenings increase, is improving strategies to meet the 100% goal. This task becomes more complex as increased attention related to the behavi oral health needs of very young children increases. In the past, the need for these services and a child's eligibility for these services were based on education based domains of development. Strategies must be developed to assure referrals of children who are not yet of school age.

In 2005 EI/ILP discovered that 58% of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15%. 182 children (10%) had social and emotional delays greater than 50%. Current programs do not have the capacity to provide adequate training and support to address the social and emotional needs of children currently enrolled in services, much less children with difficulties solely in social and emotional delays. Since 2003, Alaska has seen a 56% increase in the number of referrals from child protective services and expects this number to rise as child protection services and EI/ILP continue to improve communication and understanding of how best to provide supports to these children and families.

In 2007 EI/ILP continues to identify an increase in children demonstrating delays in social and emotional development and continues to promote resource development in the area of identification and appropriate treatment training for staff to address the issue. EI/ILP currently has a cohort of six providers receiving training in the treatment of social and emotional delays.

A total of 2,552 children were referred from all sources in FY 2007. Of the total, 525 children were referred specifically from Child Protective Services -- 21% of all referrals, whereas in 2004 there were 155 children referred to infant learning from child protective services. This represents a significant increase of close to 240% in referrals over a three year period with 2007 representing only three quarters of data.

Of 90 referrals in Fairbanks in FY 2007, 10 children were enrolled in the program. This was an increase of

2% enrolled over FY 2006 that showed 71 referrals and seven enrollments. In Mat-Su six children where enrolled out of 30 referred in FY 2007 over 11 referrals and no enrollments in the program in FY 2006. Anchorage referred 178 children and enrolled 26 of those children in FY 2007. In FY 2006, Anchorage referred 128 children and enrolled 23 in the program.

A1: Strategy - Improve the referral process from Children's Protective Services to Early Intervention/Infant Learning Program services.

Target #1: Increase the percentage of child protection services referrals provided to children ages 0-3 and attain federal compliance.

Measure #1: Change in the percentage of completed referrals.

Percent of Early Intervention/Infant Learning Program Referrals

Year	Total Referrals	CPS Referrals	Percent	Target
FY 2003	1879	169	8.9%	
FY 2004	2134	248	11.6%	
FY 2005	2201	280	12.7%	
FY 2006	2357	363	15.4%	
FY 2007	2552	525	20.6%	5% increase

Data Source: OCS Early Intervention/Infant Learning Unit

Analysis of results and challenges: The Early Intervention/Infant Learning Program (EI/ILP) goal is to continue to increase the percentage of referrals of children who come to the attention of Child Protection Services (CPS).

As shown above, the program has made steady progress for the past five years, but still has work to do. Not only do the number of referrals and screenings need to go up, but the availability of services required as a result needs to increase. Currently, programs do not have the capacity to provide adequate training and support to address the social and emotional needs of these children. Provider training is currently on-going.

The significant increase in the number of CPS referrals is a good indicator of increased understanding and communication.

A2: Strategy - To reunify children in out-of-home placements with parents or caretakers as soon as it is possible.

Target #1: Increase the rate of children reunified with their parents or caretakers within 12 months of removal. **Measure #1:** The percent of children reunified with parents or caretakers at the time of discharge from foster care in less than 12 months from the last removal.

Rate of Reunification

Year	Alaska Rate	National Standard
FFY 2001	62.4%	76.2%
FFY 2002	53.3%	76.2%
FFY 2003	54.7%	76.2%
FFY 2004	54.7%	76.2%
FFY 2005	53.3%****	76.2%
FFY 2006	61.5%	76.2%
FFY 2007	50.7%	76.2%

This measure is based on children returned to parents or caretakers in less than 12 months from the time of the latest removal and is calculated annually.

Data Source: Alaska's Online Resources for the Children of Alaska submission to the National Child Abuse and Neglect Data System.

****Introduction of the Online Resources for the Children of Alaska (ORCA) case management system. With the transition from the old case management system (PROBER) to the new ORCA system, data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal methodology for computing measures remains the same, measures

computed from these two different systems should not be considered comparable.

Analysis of results and challenges: This measure represents the percentage of children that were returned to their parents or caretakers in less than twelve months from the time of the latest removal, known as the rate of reunification. While the Office of Children's Services (OCS) did achieve its goal as mandated by the Federal Performance Improvement Plan, there is much room for improvement in reunifying children with their families in a twelve month period.

With so much effort being placed on the new rollout of the safety assessment and emphasis on the front end of an OCS intervention to keep children safe, outcomes aimed at achieving permanency for children have decreased.

Efforts to improve this measure include collaboration with the Court Improvement Committee to highlight the need for Assistant Attorney Generals, Guardians ad Litem, Court Appointed Special Advocates, and judges to assist in helping the OCS to achieve permanency goals more timely.

By implementing the new safety model, permanency workers will be better equipped to determine whether children can be returned to their families sooner if the safety threats have been remedied and risk factors are all that remain. The premise behind the new safety model encourages workers to continue to assess through the life of the case whether children can be safely returned to their parents before all of the case plan requirements are met. If the reason OCS took children into custody was due to the child being unsafe, then the threshold for their return ought to be the same. Ongoing case plans can be monitored with children in their homes more easily with the family reunified than by requiring the family achieve success by reducing all the risk factors as well.

This model provided that the grantees use an assessment process to be completed with the family upon entry into the program and at different intervals in the life of the case, in order to assess the progress and safety factors as well as increase family functioning to ensure reunification. The grantees also provide for an inhome component to provide face-to-face contact with the family to gather assessment information and formulate a reunification plan. Reunification data is being captured from quarterly narrative reports and results should be available January, 2008.

B: Result - Safe and timely adoptions.

Target #1: Increase the annual number of completed adoptions. **Measure #1:** Number of children placed in adoptive homes annually.

Number of Children Adopted from State Custody by Federal Fiscal Year

Year	Children Adopted	Annual Change
FFY 2001	278	75
FFY 2001	222	-56
FFY 2003	201	-21
FFY 2004	179	-22
FFY 2005	191	12
FFY 2006	197	6
FFY 2007	221	24

Data Source: Online Resources for the Children of Alaska (ORCA)

This data is provided through the federal Administration for Children and Families (ACF). Raw data provided by ORCA is sent to Washington DC for processing with results returned to Alaska in late October. This measure cannot be updated until that time.

OCS anticipates having the ability to report quarterly outside of the federal process for quarter ending September 31.

Analysis of results and challenges: Since the passage of the Adoption and Safe Families Act of 1997, Alaska has seen an increase in the number of finalized adoptions for children from the Office of Children's Services (OCS) custody. As of June 30, 2006, there were 1,989 children (approximately 87% federally funded and 13% state funded) in the subsidized adoption program. Each year the OCS sees at least 150 children who are able to achieve permanency through adoption in the OCS system. The chart above shows the

number of finalized adoptions as reported by Federal Fiscal Year. It is anticipated that over the next year the adoptions of children in the OCS custody will increase as OCS places continued emphasis on meeting the 15 out of 22 month timeframes outlined in the Adoption and Safe Families Act.

B1: Strategy - Promote the use of adoption exchanges to recruit adoptive homes.

Target #1: Increase recruitment of resource family homes.

Measure #1: Number of resource family homes recruited annually.

Number of Resource Family Homes Recruited Annually

Year	Initial Inquiries	# of Families Processed	Percent Processed
2006	102	63	62%
2007	to come	to come	to come

Data Source: Office of Children's Services Adoption Subsidy Unit.

FY 2006 marks the first year this plan was administered by the Adoption Subsidy Unit.

Analysis of results and challenges: The Office of Children's Services (OCS) participates in a state. regional, and national adoption exchange to assist with the identification of potential adoptive families for children in the OCS custody. The exchanges provide an opportunity to list the child and describe the family that would be best suited to meet the child's special needs in an effort to locate a family to adopt the child.

In Alaska, the use of the Alaska, Northwest and AdoptUsKids exchanges allows for the OCS to reach a broader network of waiting adoptive families throughout Alaska and the United States.

A total of 102 potential resource families made initial inquiries to the OCS for information on becoming a licensed resource family with the OCS. Of these 102 families, 63 families (60% of the initial inquiries) continued with the resource family orientation, training and licensing process with the OCS. OCS intends to increase the percentage of resource families who initiate the resource family licensing process to 70% of the total number of initial inquiries during the next fiscal year.

B2: Strategy - Promote the adoption of older youth ages 12 - 18.

Target #1: Increase the number of adoptions for youth age 12-18.

Measure #1: The annual number of youth age 12-18 who are adopted.

Number of Youth Age 12 - 18 Adopted by Federal Fiscal Year

Year	# Adopted	Change
FFY 2005	36	0
FFY 2006	36	0
FFY 2007	35	0

Data Source: Online Resources for the Children of Alaska (ORCA) to the federal Adoption and Foster Care Analysis and Reporting System (AFCARS)

ORCA data is provided to the federal Administration for Children and Families (ACF) biannually. The data is processed by the ACF and results are returned to the state.

Analysis of results and challenges: In the summer of 2006, the national focus for adoption was on the adoption of older youth from the child protection system. In Alaska, the focus on the increase of older youth adoptions (children 12-18 years of age) is a specific target for the next fiscal year. National research studies have indicated that children who age out of the foster care system have greater life challenges than children who leave the foster care system with connections to significant adults (parents, mentors, adoptive parents, guardians). For this reason, the OCS has focused on assisting older youth with developing and maintaining permanent connections in their lives, and for many of these youth, the connections will need to be legally permanent as well.

In FFY 2005, 36 children between the ages of 12-18 were adopted through the OCS foster care system. In

FFY 2006, this number remained consistent within the same age group. There was only 1 fewer child between the ages of 12 and 18 that was adopted in FY 2007.

In FY 2007 nearly 14% of the total new adoptions were of children age 12 - 18.

Health Care Services Results Delivery Unit

Contribution to Department's Mission

To provide health coverage to Alaskans in need.

Core Services

- Provide access to appropriate health care services; and
- Assure access to a full range of health care service information to our customers.

The Division of Health Care Services (HCS) supports the following Medicaid core services for:

- Hospitals, physician services, pharmacy, dental services, transportation, physical, occupational, and speech therapy;
- Laboratory and x-ray;
- Vision, Family Planning;
- Durable medical equipment; and
- Hospice and home health care.

Department wide, HCS administers the State Children's Health Insurance Program (SCHIP), the Medicaid Management Information System (MMIS), claims payments and accounting, third-party liability collections and recoveries, federal reporting activities, Medicaid Administrative Claiming, Medicaid Error Rate program, and the Chronic and Acute Medical Assistance program.

HCS also administers the following programs:

- <u>Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program</u> The EPSDT program assures that children enrolled in Medicaid receive preventive health care and additional diagnosis or treatment services as needed. Good quality preventive health care reduces subsequent medical care costs for these children. All Medicaid Services/EPSDT program activities are directed toward addressing federal EPSDT regulations and related federal initiatives. The program sends notices to parents or guardians of children due for well-child exams and immunizations; assists families in finding physicians, nurse practitioners, dentists and vision care providers in their home community who accept new Medicaid patients; and coordinates and funds transportation reimbursement to preventive health care appointments for children and pregnant women. Reimbursement assistance is available for health care appointments if the family would not otherwise be able to afford to attend the appointment.
- <u>The Chronic and Acute Medical Assistance Program (CAMA)</u> The CAMA program provides a limited package of health services to those individuals with chronic medical conditions who do not qualify for the Medicaid program. CAMA's limited benefits are only available to low-income persons with an immediate need for medical care who are unable to secure other private or public assistance.
- <u>Tribal Health Agenda</u> The HCS is playing an integral role in the Tribal Health Agenda. Projects with tasks falling to HCS include developing policy that will enable tribes to bill for services under management contracts; reviewing new estate recovery policy; ensuring tribes that provide public health nursing services are included in the plan for Medicaid reimbursement; providing administrative, training and claims processing services for Tribal Medicaid Administrative Claims (Tribal MAC) agreements; providing support for data analysis, reporting, and training of tribes; and developing "due" lists to support tribes who have continuing care provider agreements.

End Result	Strategies to Achieve End Result
A: Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds.	A1: Increase Indian health services (IHS) participation by 5% in expenditures.
Target #1: Reduce by 1% the GF expenses and replace them with alternate funds.	<u>Target #1:</u> Increase Indian health services (IHS) Medicaid participation by 5% in expenditures. <u>Measure #1:</u> Percentage of IHS direct service
Measure #1: Percent of general funds replaced with alternate funding.	expenditures.
	A2: Expand fund recovery efforts.
	<u>Target #1:</u> Increase funds recovered by 2%. <u>Measure #1:</u> Change in amount of funds recovered.
End Result	Strategies to Achieve End Result
B: To provide affordable access to quality health care services to eligible Alaskans.	B1: Improve time for claim payment.
J	Target #1: Decrease by .5% the average time HCS
Target #1: Increase by 2% the number of providers	takes to pay a claim.
enrolled in Medicaid. Measure #1: Change in number of providers enrolled in Medicaid.	Measure #1: Change in the average time HCS takes to pay a claim.
	B2: Improve payment efficiency.
	Target #1: Increase percentage of claims paid by provider without error to promote timely and accurate
	payment. <u>Measure #1:</u> Change in percentage of adjudicated claims paid with no provider errors.

FY2009 Resources Allocated to Achieve Results		
Personnel: Full time	91	
Part time	0	
Total	91	
	Personnel: Full time Part time	

Performance Measure Detail

A: Result - Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds.

Target #1: Reduce by 1% the GF expenses and replace them with alternate funds.

Measure #1: Percent of general funds replaced with alternate funding.

Health Care Services Actuals - Other Funds (in millions)

Year	% Federal	% General	% Other
FY 1999	66.0%	34.7%	.8%
FY 2000	65.3%	25.5%	9.2%
FY 2001	66.4%	22.7%	10.9%
FY 2002	66.6%	27.8%	6.1%
FY 2003	67.5%	25.5%	7.1%
FY 2004	71.1%	16.6%	12.4%
FY 2005	71.5%	17.5%	11.0%
FY 2006	65.3%	28.1%	6.6%
FY 2007	64.8%	31.0%	4.2%

Analysis of results and challenges: Seek ways to maximize federal participation through Family Planning, Indian Health Service, Breast and Cervical Cancer, and Title XXI expenditures.

Charted numbers represent actual expenditures recorded in the Alaska Budget System (ABS) as percentages.

As a joint federal-state program, the federal and state governments share the cost of Medicaid. Federal financial participation rates are set at the federal level, and largely outside of state control. The state's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status. For most Medicaid eligibility groups and services, the portion of state Medicaid benefits paid by the federal government is called Federal Medical Assistance Percentage (FMAP).

Note: FY 2004 is the first year reported after the reorganization. FY 2004 and earlier actuals will include the complete Medicaid program (not just Health Care Services) and therefore do not provide exact comparisons between fiscal years.

A1: Strategy - Increase Indian health services (IHS) participation by 5% in expenditures.

Target #1: Increase Indian health services (IHS) Medicaid participation by 5% in expenditures. **Measure #1:** Percentage of IHS direct service expenditures.

% Increase	% of Total	IHS	Total Exp	Year
98%	16%	\$37.5	\$228.6	1999
32%	18%	\$49.4	\$268.4	2000
48%	23%	\$73.3	\$323.0	2001
22%	23%	\$89.3	\$385.9	2002
51%	29%	\$134.9	\$466.6	2003
15%	31%	\$154.5	\$503.6	2004
21%	30%	\$187.2	\$627.4	2005
-17%	25%	\$155.3	\$628.4	2006
-1%	26%	\$153.0	\$594.3	2007
, for 1999 - 2004	FairShare claims	payments, including	Expenditures include all d IHS direct services claim p S-JUCE, 2005-2007 are fro	drug rebates.

Analysis of results and challenges: Indian Health Service (IHS) expenditures decreased from FY06 to FY07 by \$2.3 million. The decrease is largely due to the termination of the FairShare program, a federally-approved program wherein the state increased payments to a tribally-operated hospital. When the program ended, provider rates, as well as expenditures, decreased.

As the program readjusts itself to not including FairShare, evaluation of quarters and state fiscal years will yield more accurate comparisons.

IHS facilities are reimbursed for Medicaid services at a 100% federal participation, whereas non-IHS facility patient costs require a state match on expenditures.

Background:

Increased IHS billing capacity by tribal entities assists with revenue generation. This directly contributes to tribal entities being able to maintain and hire staff to serve recipients closer to home on a more consistent basis. It also decreases the number of American Indian/Alaska Native (Al/AN) beneficiaries going to non-tribal facilities. Certain tribal entities with 638 status receive 100% FMAP for service delivery to Al/AN beneficiaries, thus assisting the state with maximizing federal reimbursement through Centers for Medicare and Medicaid Services IHS. In addition, the Department of Health and Social Services (DHSS) completes periodic data matches between IHS and Management Information System (MMIS) to ensure that Al/AN beneficiaries are appropriately coded in the Eligibility Information System (EIS). This allows DHSS to capture 100% FMAP vs. the standard match for non-native.

Once an Al/AN beneficiary is connected to a tribal healthcare delivery system that is able to bill Medicaid, beneficiaries can access additional service areas if needed. Depending on the door beneficiaries enter, for example, whether it's behavioral health, clinic, or dental, they become a part of the larger tribal healthcare

delivery system of that region. The more revenue they generate per service category, the more consistent the long-term system becomes.

A2: Strategy - Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.

Measure #1: Change in amount of funds recovered.

Medicaid Recoveries: Drug Rebates & Third Party Liability (TPL) Collections (in millions)

Year	Drug Rebates	TPL	Total	% Change
2003	17.0	8.0	25.0	N/A
2004	19.4	10.1	29.5	18%
2005	30.2	8.7	38.9	24%
2006	27.5	9.4	36.9	-5%
2007	19.2	3.5	22.7	-28%

Analysis of results and challenges: Health Care Services has seen an overall decline in its collections for drug rebates and third-party liability by 28% from FY06 to FY07. This is mainly attributable to a decline of drug rebate receipts that resulted from the implementation of the Medicare Part D program. More prescription drugs are covered by this federal program, therefore, there are less state expenditures that qualify for drug rebate recoveries.

B: Result - To provide affordable access to quality health care services to eligible Alaskans.

Target #1: Increase by 2% the number of providers enrolled in Medicaid.

Measure #1: Change in number of providers enrolled in Medicaid.

	Numbe	er of Provide	rs in Selecte	d Provider	Гуреѕ
		Enro	lled in Medi	caid	
1	FY2003	FY2004	FY2005	YTD FY2006	YTD FY2007
Physicians	6,440	7,076	6,486	6,406	5,553
Dentists	587	597	578	553	482
Pharmacies	359	356	287	224	198
Hospitals	734	841	739	751	602
Nursing Facili	36	33	29	32	35
Sum	8,156	8,903	8,119	7,966	6,870
Source: DHSS, Fin	ance & Mgr	nt Services			
Medicaid Budget G	roup, MARS	-MR-0-06-T			

Analysis of results and challenges: Provider enrollment is difficult to compare from any one period to another for a variety of reasons:

- 1. Provider enrollment and participation in the Alaska Medical Assistance programs is voluntary; providers may choose to end their enrollment at any time and do so for various reasons. A participating provider may enroll without rendering services, and a provider may be enrolled and stop billing for services without disenrolling.
- 2. The time limit for submission of claims is one year from the date services were rendered, and some providers wait many months to bill, which may be a factor in participation and enrollment from year to year.
- 3. Out-of-state providers may be prompted to enroll when they see an Alaska Medicaid client or when they attempt to bill for the services rendered to our clients. These providers typically cease to participate and/or maintain their enrollment status once the few claims have been paid for these out-of-state health care encounters.
- 4. There are, at present, no strategies to increase provider enrollment or participation.

Timely payment is part of the strategy for retaining providers who participate in Medicaid. Provider retention is necessary if the department is to meet its goal of affordable access to health care. While it probably does not contribute to increased provider participation, failure to pay timely could negatively impact access to care if dissatisfied providers stop seeing Medicaid patients.

B1: Strategy - Improve time for claim payment.

Target #1: Decrease by .5% the average time HCS takes to pay a claim.

Measure #1: Change in the average time HCS takes to pay a claim.

Analysis of results and challenges: This measure is reported at the department level.

B2: Strategy - Improve payment efficiency.

Target #1: Increase percentage of claims paid by provider without error to promote timely and accurate payment.

Measure #1: Change in percentage of adjudicated claims paid with no provider errors.

	FY02	FY03	FY04	FY05	FY06	FY07
Total Claims Paid (fiscal yea	4,202,677	4,776,730	5,106,692	6,150,027	6,082,318	5,606,347
Percent Paid with No Errors	74%	73%	76%	72%	74%	72%
Hospitals	60%	65%	64%	65%	64%	73%
Physicians	67%	65%	64%	63%	65%	63%
Dentists	73%	74%	74%	73%	74%	74%
Nursing Home Facilities	65%	62%	62%	49%	60%	65%
Pharmacy	83%	80%	77%	77%	79%	64%
Mental Health	73%	76%	77%	74%	75%	79%
Transportation	88%	86%	86%	75%	84%	85%
HCBC	77%	78%	81%	87%	81%	87%
Vision	80%	77%	69%	76%	75%	69%
Psych	71%	42%	47%	55%	54%	60%
Clinics	71%	58%	49%	65%	61%	62%
BRS	91%	86%	84%	87%	87%	92%
Chiropratic	60%	49%	51%	53%	53%	50%

Analysis of results and challenges: Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. First Health, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

The sharpest decrease in percentage of adjudicated claims paid with no provider errors was between the first

quarter of FY06 and FY07 in Pharmacy. During FY06, the Department of Health and Social Services (DHSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, DHSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice. Therefore, the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required DHSS to deny pharmacy claims for Medicare-covered drugs for those recipients of both Medicaid and Medicare. Previously, Medicaid paid for this same population. This results in a significant denial of claims.

These major changes to the Pharmacy program were surely noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

Juvenile Justice Results Delivery Unit

Contribution to Department's Mission

The Division of Juvenile Justice (DJJ) provides a comprehensive array of services for juveniles who have committed delinquent offenses, beginning at the point that law enforcement officers identify or apprehend juvenile offenders. The division is responsible for conducting intake interviews for these offenders; providing short-term detention when necessary; diverting juveniles from the formal court process as appropriate; providing formal probation supervision; providing court ordered institutional treatment and community re-integration (aftercare). The division's mission is to hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.

Core Services

- Short-term Secure Detention
- Court ordered institutional treatment for juvenile offenders
- Intake investigation and management of informal a or formal response
- Probation Supervision and Monitoring
- Juvenile Offender Skill Development

The division performs probation intake and supervision functions statewide and operates secure juvenile facilities in Anchorage (McLaughlin Youth Center), Palmer (Mat-Su Youth Facility), Kenai (Kenai Peninsula Youth Facility), Fairbanks (Fairbanks Youth Facility), Juneau (Johnson Youth Center), Bethel (Bethel Youth Facility), Nome (Nome Youth Facility) and Ketchikan (Ketchikan Regional Youth Facility). Probation offices are located in these same communities as well as Sitka, Prince of Wales, Kodiak, Palmer, Dillingham, Homer, Valdez, Barrow and Kotzebue.

End Result	Strategies to Achieve End Result
A: Outcome Statement #1 Improve the ability to hold juvenile offenders accountable for their behavior.	A1: Strategy 1a: Improve the timeliness of response to juvenile offenses.
Target #1: Improve the ability to collect ordered restitution at the time of case closure to 100% of what was ordered. Measure #1: Percentage of ordered restitution collected at the time of case closure compared to what was ordered. Target #2: Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered.	Target #1: Seventy-five percent of juvenile referrals will receive an active response within 30 days from the date that the report is received from law enforcement. Measure #1: The percent of delinquency referrals receiving an active response from juvenile probation within 30 days of the date the complete referral is received from law enforcement. A2: Strategy 1b: Improve the satisfaction of victims of juvenile crime.
Measure #2: Percentage of community work service hours performed by juvenile offenders compared to what was ordered.	Target #1: In FY07 the division will develop a process to track victims' satisfaction with juvenile justice services. Measure #1: Implementation of a process and/or protocol to record and assess victims' satisfaction with juvenile justice services. A3: Improve the division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the Division of Juvenile Justice (DJJ) field probation policy and procedure manual.
5)/0000	Covernor Delegand December 10th

Results Delivery Unit	— Juvenile Justice
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Target #1: Juvenile Probation Officers will achieve an
average of 95% compliance with all probation audit
standards for each one-year period measured.
Measure #1: Average % of all probation audit standards
met by probation officers over the course of the fiscal
year.

FY2009 Resources Allocated to Achieve Results				
FY2009 Results Delivery Unit Budget: \$50,203,100	Personnel: Full time	473		
, , ,	Part time	5		
	Total	478		

Performance Measure Detail

A: Result - Outcome Statement #1 Improve the ability to hold juvenile offenders accountable for their behavior.

Target #1: Improve the ability to collect ordered restitution at the time of case closure to 100% of what was ordered.

Measure #1: Percentage of ordered restitution collected at the time of case closure compared to what was ordered.

Year	Amt Ordered	Amt. Completed	% of Amt Ordered	Goal
2005	\$70,911.28	\$69,343.23	97%	100%
2006	\$58,576.80	\$55,821.90	95%	100%
2007	\$92,785.90	\$83,158.30	90%	100%

Amount completed is amount at case closure.

Analysis of results and challenges: While the percentage of restitution completed at case closure appears to have decreased between FY06 and FY07, the overall amount of restitution recorded as requested and paid increased, indicating that division staff are doing a thorough job of entering restitution information in the division's Juvenile Offender Management Information System (JOMIS). FY07 marked the first full year that staff has used JOMIS to record restitution information. It is believed that this change has resulted in more thorough and accurate reporting of restitution than in years past. The percentage collected indicates that the Division of Juvenile Justice (DJJ) staff continues to demonstrate a high degree of effectiveness in collecting restitution payments.

This measure provides a gauge of the division's effectiveness in assisting youths in their efforts to make reparations to those impacted by their criminal behavior. Juvenile probation officers are responsible for ordering and monitoring payments made outside the formal court system. Restitutions assigned through informal procedures are included in this measure, as are assignments of Permanent Fund Dividends made by juvenile probation officers. The amount of restitution reported as paid is that amount provided by the youth at the time of case closure. Restitutions tracked and gathered through youth courts and other community diversion programs are not included in this measure for FY06 and FY07. Since January 1, 2002, restitution payments by juveniles who are adjudicated formally through the Alaska Court System have been tracked, collected, and reported by the Alaska Department of Law Collections and Support Unit and those restitution payments are also not included in this analysis.

Note: FY06 and FY07 data for this measure was retrieved from the JOMIS report, "Statewide Summary

Restitution Report," on August 13, 2007. This data is continually refined and corrected and numbers in future reports may change slightly.

Target #2: Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered.

Measure #2: Percentage of community work service hours performed by juvenile offenders compared to what was ordered.

Community Work Service Hours

Year	Hours Ordered	Hours Completed	Percentage	Goal
FY 2005	34,167	30,642	90%	100%
FY 2006	35,059	28,730	81%	100%
FY 2007	32,141	25,979	81%	100%

Hours completed are at closure of service record.

Analysis of results and challenges: The percentage of community work service completed compared to what was ordered held steady through FY07, the second full year that the Division tracked this measure through its Juvenile Offender Management Information System. This is an encouraging finding because it indicates that the data entry procedures for staff are being used consistently, and that the division can next devote its attention to improving community work service completion rates.

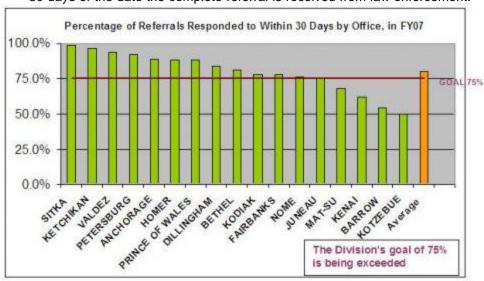
Like restitution, community work service is a way for juveniles to repair harm caused to those impacted by juvenile crime. The record of community work service must have been closed in the target fiscal year to be included in this measure. Community work service ordered both through formal, court-ordered processes or informal processes directed by a juvenile probation officer are included in this measure. Community work service ordered through youth courts or other alternative justice processes are not included.

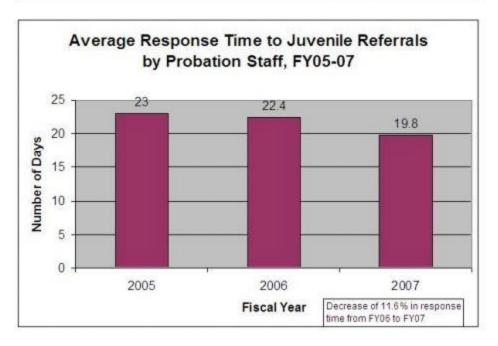
Note: Data for this measure for FY06 and FY07 was retrieved from the JOMIS report, "Statewide Summary Community Work Service Report," on August 13, 2007. This data is continually refined and corrected and numbers in future reports may change slightly.

A1: Strategy - Strategy 1a: Improve the timeliness of response to juvenile offenses.

Target #1: Seventy-five percent of juvenile referrals will receive an active response within 30 days from the date that the report is received from law enforcement.

Measure #1: The percent of delinquency referrals receiving an active response from juvenile probation within 30 days of the date the complete referral is received from law enforcement.





Statewide Average for Last Three Fiscal Years

Year	Average	Target
2005	76%	75%
2006	78%	75%
2007	80%	75%

Over the last three years, the division has exceeded the goal of 75% and has continuously improved.

Analysis of results and challenges: This measure enables the division to monitor the percentage of cases that receive an active response within the target response time of 30 days. An "active response" is defined by the division as one of three possible actions by staff to deal with the delinquency report (see note below). Research indicates that in order to be effective, responses to juvenile crime must be timely and appropriate to

the level of the offense. The first chart above illustrates the percentage of referrals that received a response within 30 days of the date the referral was received by each office in Alaska. The statewide average was 80%, exceeding the goal of 75%. The second chart illustrates the average number of days it took to actually respond to all referrals. The average response time in FY07 was 19.8 days, an improvement from prior years. Response time information is provided through the Juvenile Offender Management Information System (JOMIS).

Note: Delinquency reports, or "referrals" included in this analysis were those received in the fiscal year that resulted in one of the following actions: Referral Screening (review of the police report and either closing the referral or forwarding it to a community accountability program, such as youth court), Petition Filed (resulting in an adjudication or dismissal by the court), or Intake Interview (which may result in referral being adjusted, dismissed, petitioned, or forwarded to a community accountability program).

A2: Strategy - Strategy 1b: Improve the satisfaction of victims of juvenile crime.

Target #1: In FY07 the division will develop a process to track victims' satisfaction with juvenile justice services.

Measure #1: Implementation of a process and/or protocol to record and assess victims' satisfaction with juvenile justice services.

Analysis of results and challenges: The division was successful in meeting this qualitative goal this year, thanks to close collaboration with the department's Information Technology Section. By the end of FY07 several hundred surveys had been generated through an application that interfaced with the division's Juvenile Offender Management Information System, and these were distributed to recent victims of juvenile crime. The surveys were sent out so late in the fiscal year that less than 15 were returned by fiscal year end. During FY08, we will review all surveys and gather information from them to help us gain better perspectives.

The survey is designed as a tri-fold mailing that can be completed on paper and returned to the division Director's Office, or that can be completed online. The division's goals for FY08 will be to refine and improve the application that generates this survey, and to generate at least 100 responses. The responses should provide a clear understanding of victim perceptions of the Division of Juvenile Justice and its success in helping them recover from the damage caused by juvenile crime.

A3: Strategy - Improve the division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the Division of Juvenile Justice (DJJ) field probation policy and procedure manual.

Target #1: Juvenile Probation Officers will achieve an average of 95% compliance with all probation audit standards for each one-year period measured.

Measure #1: Average % of all probation audit standards met by probation officers over the course of the fiscal year.

Juvenile Probation Region	# of Officers Audited	Average Audit Compliance Rate	Goal
Anchorage	26	97.1%	95%
Southcentral	18	93.3%	95%
Southeast	11	96.2%	95%
Northern	16	91.5%	95%
TOTAL	71	95%	95%

Note: 95% in the middle column above represents the overall audit compliance rate for officers audited, rather than the average of the four regional averages.

Average Compliance Rate for Last Three Fiscal Years

Year	Average	Target
2005	95%	95%
2006	95%	95%
2007	95%	95%

The division continues to meet the 95% target.

Analysis of results and challenges: The data indicates that juvenile probation officers have been successful in meeting the goal of 95% audit compliance. This measure monitors the division's success in achieving compliance with casework expectations for juvenile probation officers as specified in the DJJ Field Probation Policy and Procedure Manual. Supervisory audits of each probation officer's caseload were conducted on a quarterly or trimester basis. (The division adopted a policy to conduct audits on a trimester basis partway through the year.) A representative sample of each officer's caseload is audited, and the results used as a constructive means to assess an officer's performance in carrying out the required duties of the position and to ensure the delivery of appropriate services to each client. The division is continuing to examine the format and method used to conduct audits of probation casework, to attempt to make these audits an even more useful tool in determining the quality of juvenile probation officers' work.

Public Assistance Results Delivery Unit

Contribution to Department's Mission

The mission of the Division of Public Assistance is to promote self-sufficiency and provide for basic living expenses to Alaskans in need.

To meet this mission, the division administers programs that provide temporary economic support to needy families and individuals, financial assistance to the elderly, blind and disabled, food support and nutrition education, medical benefits, and supportive services that enable and encourage Alaskans to pursue economic independence and self-sufficiency.

Core Services

- Provide temporary financial assistance to low-income Alaskan families with children to help them meet their basic needs and encourage family self sufficiency and stability by planning for self-support through employment.
- Provide employment assistance to low-income Alaskan families with children to help them become more selfsufficient.
- Provide financial assistance to low-income elderly, blind, or disabled Alaskans incapable of self-sufficiency to help them meet their basic needs and remain as independent as possible in the community.
- Provide food assistance to low-income Alaskans to decrease their incidence of food insecurity.
- Provide home heating assistance to low-income Alaskans to reduce their disproportionate burden of home heating costs.
- Provide child care subsidies to families who need child care to work or participate in approved work or training activities.
- License child care providers to promote safety and quality of child care in Alaska.
- Provide access to health care by determining eligibility for Medicaid and Denali KidCare.

Public Assistance staff determines applicant eligibility and provide cash, nutrition, work supports and heating assistance to needy Alaskans. The major programs are Alaska Temporary Assistance (ATAP), Food Stamps, Adult Public Assistance (APA), General Relief Assistance, Heating Assistance, Senior Benefits, Child Care Assistance, Women, Infant and Children (WIC), and Native Family Assistance. These programs provide an economic safety net for individuals and families that need help to support them and their children. Preventing dependency, promoting self-sufficiency and supporting clients toward obtaining employment and jobs capable of supporting a family are major responsibilities of the division. Public Assistance staff also determines eligibility for Chronic and Acute Medical Assistance, Medicaid, and Denali KidCare. To qualify for public assistance, individuals must have income near or below poverty level and also meet a number of specific eligibility requirements which vary by program. The division must meet payment accuracy requirements, work participation standards and timeliness guidelines or be subject to federal sanction or penalty.

End Result	Strategies to Achieve End Result
A: Low income families and individuals become economically self-sufficient.	A1: Increase the percentage of temporary assistance families who leave the program with earnings and do not return for six months.
Target #1: Increase self-sufficient individuals and families by 10%. Measure #1: Rate of change in self-sufficient families.	Target #1: 90% of temporary assistance families leave with earnings and do not return for six months. Measure #1: Percentage of families that leave temporary assistance with earned income and do not return for six months.

A2: Increase the percentage of temporary assistance families with earnings.

<u>Target #1:</u> 40% of temporary assistance families with earnings.

<u>Measure #1:</u> Percentage of temporary assistance families with earnings.

A3: Increase the percentage of temporary assistance families meeting federal work participation rates.

<u>Target #1:</u> 50% of temporary assistance families meet federal work participation rates.

<u>Measure #1:</u> Percentage of temporary assistance families meeting federal work participation rates.

A4: Improve timeliness of benefit delivery.

<u>Target #1:</u> 95% of food stamp expedited service applications meet federal time requirements.

<u>Measure #1:</u> Percentage of food stamp expedited service households that meet federal time requirements.

<u>Target #2:</u> 96% of new food stamp applications meet federal time requirements.

<u>Measure #2:</u> Percentage of new food stamp applications that meet federal time requirements.

<u>Target #3:</u> 99.5% of food stamp recertification applications meet federal time requirements.

<u>Measure #3:</u> Percentage of food stamp recertification applications that meet federal time requirements.

<u>Target #4:</u> 90% of temporary assistance applications meet time requirements.

<u>Measure #4:</u> Percentage of temporary assistance applications that meet time requirements.

<u>Target #5:</u> 90% of Medicaid applications meet federal time requirements.

<u>Measure #5:</u> Percentage of Medicaid applications that meet federal time requirements.

A5: Improve accuracy of benefit delivery.

<u>Target #1:</u> 93% of food stamp benefits are accurate. <u>Measure #1:</u> Percentage of accurate food stamp benefits.

<u>Target #2:</u> 95% of temporary assistance benefits are accurate.

<u>Measure #2:</u> Percentage of accurate temporary assistance benefits.

<u>Target #3:</u> 93% of Medicaid eligibility determinations are accurate.

<u>Measure #3:</u> Percentage of accurate Medicaid eligibility determinations.

A6: Increase the percentage of subsidy children in licensed care.

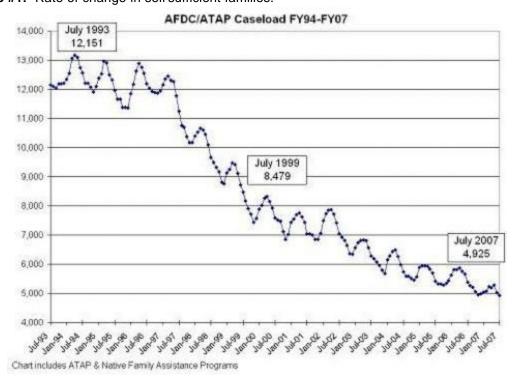
<u>Target #1:</u> 76% of subsidy children are in licensed care. <u>Measure #1:</u> Percentage of subsidy children in licensed care.

d to Achieve Resul	ts
Personnel: Full time	528
Part time	9
Total	537
	Full time Part time

Performance Measure Detail

A: Result - Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10%. **Measure #1:** Rate of change in self-sufficient families.



Changes in Self Sufficiency

Year	September	December	March	June	YTD
FY 2002	-16%	6%	4%	3%	-2%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2006	-6%	-3%	-4%	-1%	-2%
FY 2007	-2%	-8%	-10%	-10%	-7%
FY 2008	-7%	0	0	0	0
		0%	0%	0%	0%

^{*}YTD Total Column represents the average annual monthly caseload rate change.

Analysis of results and challenges: As shown in the YTD Total column, FY 2007 had a 7% decline in the number of families receiving Alaska Temporary Assistance Program benefits compared to FY 2006. The other four monthly columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

The goal is for clients to move off Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

A1: Strategy - Increase the percentage of temporary assistance families who leave the program with earnings and do not return for six months.

Target #1: 90% of temporary assistance families leave with earnings and do not return for six months. Measure #1: Percentage of families that leave temporary assistance with earned income and do not return for six months.

Percent of Temporary Assistance Families Who Leave the Program With Earnings and Do Not Return for 6 Months

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Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	83%	83%	76%	81%	81%
2003	85%	87%	82%	82%	84%
2004	90%	85%	79%	80%	84%
2005	88%	85%	80%	82%	84%
2006	87%	87%	80%	84%	85%
2007	88%	88%	86%	85%	87%
2008	86%	0	0	0	0
		0%	0%	0%	0%

Analysis of results and challenges: The goal is for clients to move off Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. The measurement ties in job retention, since retaining employment is directly related to remaining off Temporary Assistance.

The division provides childcare and supportive services to support employed families during the transition to self-sufficiency. Supportive services include case management support to continue coaching the employed client during this vulnerable period.

To calculate this measure, we divide the number of cases that closed with earnings six months ago by the number of cases that closed with earnings six months ago who are not in the current caseload. The calculation for the quarterly figures is a weighted average of the three months in the guarter. The YTD total is a weighted average of all the months so far in the year.

The FY08 target is 90%.

A2: Strategy - Increase the percentage of temporary assistance families with earnings.

Target #1: 40% of temporary assistance families with earnings.

Measure #1: Percentage of temporary assistance families with earnings.

Percent of Temporary Assistance Adults With Earnings

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	31%	28%	27%	31%	29%
2003	30%	28%	27%	32%	29%
2004	31%	29%	29%	35%	31%
2005	34%	31%	30%	35%	33%
2006	34%	32%	32%	36%	34%
2007	36%	32%	32%	36%	34%
2008	35%	0	0	0	0
		0%	0%	0%	0%

Analysis of results and challenges: This is a measure of current Temporary Assistance recipients who have earned income. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of recipients with earned income. The goal of the division's welfare to work effort is to move families off assistance and into a job that pays well enough for the family to be self-sufficient.

The calculation for the quarterly figures is a weighted average of the three months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY08 target is 40%.

A3: Strategy - Increase the percentage of temporary assistance families meeting federal work participation rates.

Target #1: 50% of temporary assistance families meet federal work participation rates.

Measure #1: Percentage of temporary assistance families meeting federal work participation rates.

Percentage of temporary assistance families meeting federal work participation rates.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	38%	37%	36%	36%	36%
2003	32%	33%	33%	34%	34%
2004	36%	36%	36%	37%	37%
2005	39%	37%	39%	40%	40%
2006	42%	43%	44%	44%	44%
2007	47%	46%	46%	50%	47%
2008	44%	0	0	0	0
		0%	0%	0%	0%

Analysis of results and challenges: Temporary Assistance (TA) is a work-focused program designed to help Alaskans plan for self-sufficiency and to make a successful transition from welfare to work. Federal law requires the state to meet work participation requirements. Failure to meet federal participation rates results in fiscal penalties.

The quarterly figures are YTD figures. The federal participation rate calculation is a running YTD figure.

The FY08 target is 50%.

As Alaska's TA caseload declines, a growing portion of the families require more intensive services just to meet minimal participation requirements. Enhancement of TA Work Services will serve to identify and address client challenges to participation.

In FY06, the Division of Public Assistance (DPA) began a family centered services initiative to increase the self-sufficiency and self-responsibility of Alaska Temporary Assistance families with complex issues and multiple barriers to self-sufficiency.

Family Centered Services assess the service needs of all members of a temporary assistance family, not just the adults who are required to participate in work activities. Program coordinators work with local Job Center partners and field staff from different programs, divisions, departments and community agencies to weave collective goals into integrated service plans to help families with complex challenges achieve a healthier self-sufficient family structure. This requires a much more collaborative and coordinated planning effort. Family Centered Services also uses a "customized employment" method of finding job opportunities for individuals participating in the project.

In FY06, DPA conducted Family Centered Services pilot projects in Fairbanks and the Mat-Su valley. Results of the pilot projects show families participating have an increase in hours of participation in work and work-related activities, an increase in average monthly earnings, and an increase in the number of months of earnings.

A4: Strategy - Improve timeliness of benefit delivery.

Target #1: 95% of food stamp expedited service applications meet federal time requirements. **Measure #1:** Percentage of food stamp expedited service households that meet federal time requirements.

Percentage of food stamp expedited service households that meet federal time requirements

r crecintage	creentage of rood stamp expedited service households that meet rederal time requirements						
Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD		
2002	95.4%	94.5%	93.4%	93.4%	93.4%		
2003	94.0%	90.5%	90.8%	92.1%	92.1%		
2004	93.2%	93.8%	94.5%	94.7%	94.7%		
2005	90.9%	92.3%	92.7%	93.5%	93.5%		
2006	95.0%	95.6%	96.0%	95.7%	95.7%		
2007	96.5%	96.2%	96.3%	96.4%	96.4%		
2008	93.1%	0	0	0	0		
		0%	0%	0%	0%		

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The quarterly data are YTD figures. The FY08 target is 95%.

Target #2: 96% of new food stamp applications meet federal time requirements. **Measure #2:** Percentage of new food stamp applications that meet federal time requirements.

Percentage of new food stamp applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	93.0%	94.2%	94.3%	94.7%	94.7%
2003	95.9%	95.1%	95.1%	95.5%	95.5%
2004	96.2%	96.1%	96.3%	96.5%	96.5%
2005	95.2%	95.5%	95.7%	95.9%	95.9%
2006	95.4%	95.9%	96.1%	96.2%	96.2%
2007	97.2%	97.3%	97.2%	97.1%	97.1%
2008	94.8%	0	0	0	0
		0%	0%	0%	0%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY08 target is 96%.

Target #3: 99.5% of food stamp recertification applications meet federal time requirements.

Measure #3: Percentage of food stamp recertification applications that meet federal time requirements.

Percentage of food stamp recertification applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	99.8%	99.8%	99.7%	99.6%	99.6%
2003	99.5%	99.5%	99.4%	99.4%	99.4%
2004	99.6%	99.6%	99.6%	99.6%	99.6%
2005	99.5%	99.5%	99.5%	99.6%	99.6%
2006	99.4%	99.5%	99.5%	99.5%	99.5%
2007	99.7%	99.5%	99.5%	99.1%	99.1%
2008	94.6%	0	0	0	0
		0%	0%	0%	0%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY08 target is 99.5%.

Target #4: 90% of temporary assistance applications meet time requirements.

Measure #4: Percentage of temporary assistance applications that meet time requirements.

Percentage of Temporary Assistance applications that meet time requirements

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Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD		
83%	86%	85%	86%	86%		
90%	88%	89%	90%	90%		
88%	88%	88%	88%	88%		
85%	84%	85%	85%	85%		
88%	86%	86%	87%	87%		
85%	83%	83%	84%	84%		
	Quarter 1 83% 90% 88% 85% 88%	Quarter 1 Quarter 2 83% 86% 90% 88% 88% 88% 85% 84% 88% 86%	Quarter 1 Quarter 2 Quarter 3 83% 86% 85% 90% 88% 89% 88% 88% 88% 85% 84% 85% 88% 86% 86%	Quarter 1 Quarter 2 Quarter 3 Quarter 4 83% 86% 85% 86% 90% 88% 89% 90% 88% 88% 88% 88% 85% 84% 85% 85% 88% 86% 86% 87%		

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need

them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY08 target is 90%.

Target #5: 90% of Medicaid applications meet federal time requirements.

Measure #5: Percentage of Medicaid applications that meet federal time requirements.

Percentage of Medicaid applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	89%	90%	89%	89%	89%
2003	91%	90%	90%	90%	90%
2004	88%	91%	91%	91%	91%
2005	92%	91%	91%	90%	90%
2006	89%	88%	89%	89%	89%
2007	88%	84%	78%	78%	78%
2008	71%	0	0	0	0
		0%	0%	0%	0%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Recent changes in federal eligibility requirements, such as verification of citizenship, have greatly increased the complexity and processing time for each Medicaid application handled. During the first half of FY08 processing times have far exceeded the 30-day standard and as a result, children have not received timely medical care, and payments to vendors and medical care providers have been delayed. The implementation of the federal Payment Error Rate Measurement (PERM) requirements further impacts processing timeframes by establishing higher expectations for program accountability and payment accuracy.

The FY08 target is 90%.

A5: Strategy - Improve accuracy of benefit delivery.

Target #1: 93% of food stamp benefits are accurate.

Measure #1: Percentage of accurate food stamp benefits.

Percentage of accurate food stamp benefits

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	90.4%	92.4%	90.5%	89.2%	89.2%
2003	86.2%	84.7%	85.6%	86.4%	86.4%
2004	90.8%	94.2%	93.5%	93.3%	93.3%
2005	92.2%	93.2%	93.0%	93.8%	93.8%
2006	92.3%	93.5%	94.1%	94.3%	94.3%
2007	95.1%	96.3%		0	96.3%
			0%	0%	

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The FFY08 target is 95%.

Target #2: 95% of temporary assistance benefits are accurate.

Measure #2: Percentage of accurate temporary assistance benefits.

Percentage of accurate temporary assistance benefits.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	88.2%	93.7%	93.6%	92.0%	92.0%
2003	94.4%	93.6%	94.5%	93.6%	93.6%
2004	96.7%	97.5%	98.2%	98.1%	98.1%
2005	98.5%	95.9%	95.7%	97.1%	97.1%
2006	98.1%	96.3%	97.7%	96.3%	96.3%
2007	99.4%	99.3%	0	0	99.3%
			0%	0%	

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

Based on successes to date, the target percentage is revised to 98% for FFY08.

Target #3: 93% of Medicaid eligibility determinations are accurate.

Measure #3: Percentage of accurate Medicaid eligibility determinations.

Percentage of accurate Medicaid eligibility determinations

Year	YTD
2002	96%
2003	99%
2004	99%
2005	93%
2006	95%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. Medicaid eligibility accuracy is compiled at the end of projects designed by the state and accepted by federal authorities.

A6: Strategy - Increase the percentage of subsidy children in licensed care.

Target #1: 76% of subsidy children are in licensed care.

Measure #1: Percentage of subsidy children in licensed care.

Percentage of subsidy children in licensed care

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Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	0	60%	58%	64%	64%
2003	65%	66%	68%	75%	75%
2004	75%	76%	76%	76%	76%
2005	74%	81%	77%	80%	77%
2006	80%	84%	75%	72%	78%
2007	74%	74%	76%	74%	75%

Analysis of results and challenges: The first available data regarding this measure is the second quarter in

2002.

There is a two month lag in the data.

Although the Child Care Assistance program subsidizes the cost of child care for eligible working families, there is a gradually widening gap between current market rates for child care services, and the state subsidy rate. State rates for child care assistance have not been raised since 2001, except for the Fairbanks area, where rates were raised in 2006 to match rates in Southeast and Anchorage. As state rates decline in relation to the market rate, low income families on child care assistance are faced with an increased financial burden to pay the difference between the state rate and the child care provider's rate (in addition to their required co-payment) or choosing lower priced and usually lower-quality child care.

Public Health Results Delivery Unit

Contribution to Department's Mission

The mission of the Division of Public Health is to protect and promote the health of Alaskans.

Core Services

The Division of Public Health core services are:

- Prevention and control of epidemics and the spread of infectious disease;
- Prevention and control of injuries;
- Prevention and control of chronic disease and disability;
- Preparation for and response to disasters (natural disasters and terrorist attacks);
- Assurance of access to early preventive services and quality health care;
- Protection of the population against environmental hazards that impact human health; and
- Ensuring effective and efficient management and administration of public health programs and services.

These services are primarily population-based and focused on achieving and preserving the health and well-being of entire communities and populations. Professional staff monitor and assess the health status of Alaskans through the collection and analysis of vital statistics, behavioral risk factor data, and data on disease and injury, including forensic data from postmortem examinations. The division uses the data and other scientific information and expertise to develop sound policy and deliver disease control and health promotion services to protect and improve the health of Alaskans.

The division helps achieve public health goals by assuring public health services are available through encouraging, supporting and sometimes requiring their development by others, and by providing services directly when unavailable from other providers. Staff also conduct disease surveillance and investigation and provide treatment consultation, case management and laboratory testing services to control outbreaks of communicable diseases and prevent epidemics. The division promotes healthy behaviors by educating citizens and mobilizing and supporting community action to reduce health risks. Outreach activities are conducted to link high-risk and disadvantaged people to needed services, direct treatment and clinical preventative services.

End Result	Strategies to Achieve End Result
A: Outcome Statement: Healthy people in healthy communities	A1: Reduce the risk of epidemics and the spread of infectious disease.
Target #1: Alaska's TB rate is less than 6.8/100,000 population. Measure #1: TB rate.	Target #1: 95% of persons with TB will complete adequate treatment within one year of beginning treatment. Measure #1: Percent of persons with TB completing
Target #2: Alaska's chlamydia rate is less than 590/100,000 population. Measure #2: Chlamydia rate.	treatment regimen. Target #2: At least 98% of chlamydia cases will be
Target #3: Alaska's coronary heart disease death rate is less than 120/100,000 population. Measure #3: Heart disease death rate.	prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines. Measure #2: Percent of persons with chlamydia prescribed adequate treatment regimen.
Target #4: Alaska's overall cancer death rate is less than 180/100,000 population. Measure #4: Cancer death rate.	A2: Reduce suffering, death and disability due to chronic disease.

<u>Target #5:</u> Reduce Alaska's unintentional injury death rate to 50/100,000 population.

Measure #5: Unintentional injury death rate.

<u>Target #1:</u> Less than 17% of high school youth in Alaska smoke.

Measure #1: Prevalence of smoking among Alaskan youth.

A3: Reduce suffering, death and disability due to injuries.

Target #1: Increase seatbelt use to 80%.

Measure #1: Percent of properly restrained occupants in a motor vehicle.

A4: Assure access to early preventative services and quality health care.

<u>Target #1:</u> More than 60% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects.

<u>Measure #1:</u> Percent of women reporting knowledge of folic acid benefits.

<u>Target #2:</u> 100% of Alaska's licensed and certified longterm care facilities are surveyed and recertified annually. <u>Measure #2:</u> Percent of licensed and certified long-term care facilities surveyed and recertified annually.

A5: Minimize loss of life and suffering from natural disasters and terrorist attack.

<u>Target #1:</u> 25% of the Division of Public Health (DPH) staff is trained in disaster response techniques and procedures.

Measure #1: Percent of DPH staff trained.

A6: Reduce Alaskans' exposure to environmental human health hazards.

<u>Target #1:</u> State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals.

Measure #1: Each new testing method validated as required by Clinical Laboratory Improvement Amendments (CLIA).

FY2009 Resources Allocated to Achieve Results

FY2009 Results Delivery Unit Budget: \$97,442,700

Personnel:
Full time 519
Part time 16

Total 535

Performance Measure Detail

A: Result - Outcome Statement: Healthy people in healthy communities

Target #1: Alaska's TB rate is less than 6.8/100,000 population.

Measure #1: TB rate.

Annual TB Rate per 100,000 population

Year	US	Alaska
2000	5.8	17.2
2001	5.6 -3.45%	8.5 -50.58%
2002	5.2 -7.14%	7.6 -10.59%
2003	5.1 -1.92%	8.8 +15.79%
2004	4.9 -3.92%	6.6 -25.00%
2005	4.8 -2.04%	8.9 +34.85%
2006	4.6 -4.17%	10.4 +16.85%

Analysis of results and challenges: Tuberculosis has been a longstanding problem in Alaska and was the cause of death for 46% of all Alaskans who died in 1946. Major efforts, utilizing 10% of the entire 1946 state budget and additional federal resources, led to one of the state's most visible public health successes - major reductions in TB. Tremendous inroads have been made to control TB in Alaska, although periodic outbreaks, usually in rural Alaska, have taxed both local and state resources. In 2000, Alaska had the highest rate of TB of any state in the country and additional funding was needed to effectively control two large outbreaks. In 2004, a multi-village outbreak involving Bethel and several surrounding Yukon-Kuskokwim villages again required additional public health resources and enhanced local response efforts. Unrelated to that outbreak, four Alaskans died with TB in 2004 because of delayed diagnosis and treatment - three Alaska Native elders and a Laotian. In 2005 and 2006 Alaska again had the highest rate of TB of the 50 states. This was the result of a large outbreak among the homeless in Anchorage that has continued into 2007. On an ongoing basis, even when there are no outbreaks, significant resources are needed to do the TB case finding, diagnostic tests and treatment follow-up necessary to keep this disease in check. In addition, for every person with TB, there are, on average, 16 people who were exposed and must also be found, evaluated, and often treated as well.

Alaska's population is small, so only a few cases can dramatically affect the statewide rate. For instance, the latest increase is a difference of just 11 cases – 59 in 2005 up to 70 in 2006. Despite the recent outbreaks, the rate of TB in Alaska has shown a downward trend over the past 12 years.

Because of a high rate of latent TB infection among residents, and Alaska's location as a global crossroads that attracts travelers, seasonal workers and new families, rates of TB are expected to fluctuate and remain higher than the national average over the next generation. TB remains deeply entrenched in many regions of Alaska, while the homeless and foreign-born residents also suffer disproportionate rates of the disease.

To control the ongoing challenge of TB, the department needs a strong and multi-pronged public health team of professionals knowledgeable about current issues of TB control as well as a strong public health nursing force. Such expertise will always be necessary if the disease once called the "Scourge of Alaska" is to be controlled and eventually eliminated.

Target #2: Alaska's chlamydia rate is less than 590/100,000 population. **Measure #2:** Chlamydia rate.

Chlamydia rate per 100,000 of population

Year	Alaska	U.S.
1999	303	247
2000	410	251
	+35.31%	+1.62%
2001	433	275
	+5.61%	+9.56%
2002	593	289
	+36.95%	+5.09%
2003	602	304
	+1.52%	+5.19%
2004	604	320
	+0.33%	+5.26%
2005	657	333
	+8.77%	+4.06%
2006	676	348
	+2.89%	+4.50%

Analysis of results and challenges: Sexually transmitted infections remain major causes of illness in Alaska and may cause serious health consequences. Additionally, new infectious organisms and diseases are being detected, some diseases once under control have recently reemerged, and evolving antimicrobial resistance is rendering certain antibiotics ineffective.

Many challenges remain. More sensitive diagnostic technologies, targeted screening, and increased disease investigation activities have detected more infections, increasing the total numbers of chlamydia cases diagnosed. Rapid identification, notification, testing, and treatment of sexual contacts of individuals with chlamydia can make it possible to treat exposed individuals before they develop symptoms or further transmit infection. Conducted with sufficient intensity, these activities have been shown to reduce the reservoir of infected individuals in the population, reducing case numbers and rates over time. Expanded programmatic efforts reduced chlamydia rates in 2003-2004 but could not be sustained; rates have increased since that time.

The basic public health infrastructure for sexually transmitted disease (STD) and HIV prevention and control is in place: public health expertise for patient follow up and partner notification; high quality public health laboratory services; and capacity for epidemiologic support, data analysis, and data dissemination. Some elements of this infrastructure, especially trained personnel to conduct partner notification services, currently require additional resources to strengthen and expand them to a level sufficient to address needs. All elements require ongoing maintenance and monitoring. Most of the financial resources currently identified to support STD prevention and control are federal and have declined over the past five years. Buying power has been eroded by increased costs of living and increased Department of Health and Social Services indirect costs. New resources are needed to expand program efforts.

Target #3: Alaska's coronary heart disease death rate is less than 120/100,000 population. **Measure #3:** Heart disease death rate.

Coronary Heart disease death rate per 100,000

Year	Alaska	US
1999	131.5	194.6
2000	137.7	186.7
	+4.71%	-4.06%
2001	136.6	177.8
	-0.80%	-4.77%
2002	118	170.9
	-13.62%	-3.88%
2003	126.6	162.9
	+7.29%	-4.68%
2004	94.7	150.5
	-25.20%	-7.61%
2005	90.7	149.8
	-4.22%	-0.47%
2006	80.9	N/A
	-10.80%	

U.S. data will be updated once it is approved and released by the CDC's National Center for Health Statistics.

Analysis of results and challenges: Analysis of results and challenges: Nationally, heart disease is the leading cause of death for all Americans. An estimated 12 million men and women have a history of coronary heart disease (the most common form of heart disease). In 2003, more than 480,000 people died of coronary heart disease. Although death rates from coronary heart disease have declined since the late 1960s, the decline has slowed since 1990. The lifetime risk for developing this disease is very high in the United States. One of every two males and one of every three females aged 40 years and under will develop heart disease sometime in their life.

Heart disease is the second leading cause of death in Alaska, and cerebrovascular disease, or stroke, is the fourth leading cause of death in Alaska. Over the past decade, Alaska's age-adjusted mortality rate for coronary heart disease has continued to decline. This mirrors the national trend, although Alaska's rates fall consistently below those found in the U.S. overall. Since 2004, Alaska's coronary heart disease death rates have been below the Healthy Alaskans 2010 target, which is 120 deaths per 100,000 population.

While there are no hard data to explain the downward trend in coronary heart disease deaths, it is likely that improvements in medical care are prolonging life, even for patients with advanced heart disease. In addition, Alaskans diagnosed with heart disease sometimes move south to receive treatment; their eventual deaths are not recorded in this state.

Target #4: Alaska's overall cancer death rate is less than 180/100,000 population. **Measure #4:** Cancer death rate.

Cancer death rate per 100,000 of population

Year	Alaska	US
1999	192.5	200.8
2000	209.6	199.6
	+8.88%	-0.60%
2001	192.2	196.0
	-8.30%	-1.80%
2002	189.4	193.5
	-1.46%	-1.28%
2003	187.7	190.1
	-0.90%	-1.76%
2004	184.0	185.8
	-1.97%	-2.26%
2005	169.7	183.8
	-7.77%	-1.08%
2006	167.8	N/A
	-1.12%	

U.S. data will be updated once it is approved and released by the CDC's National Center for Health Statistics.

Analysis of results and challenges: Cancer is not a single disease, but rather a constellation of more than 100 related diseases. Everyone is at risk of cancer. In the United States, half of all men and one-third of all women will develop cancer during their lifetimes. Of the approximately 491,000 Americans who are diagnosed with cancer in any given year, four of every ten are expected to still be living five years after diagnosis. Cancer was rarely seen in Alaska during the 1950s, but in the 1990s cancer was the leading cause of death in Alaska.

Over the past 10 years, the overall cancer death rate in Alaska has declined, closely mirroring the decline seen in U.S. cancer mortality rates for the same period. However, unlike in most other states, in Alaska cancer is the number one cause of mortality. The Healthy Alaskans 2010 target is 162 deaths per 100,000 population.

The leading types of cancer deaths in Alaska for women are, in order, lung, breast and colorectal cancers. For men, the leading types of cancer deaths are lung, colorectal and prostate.

Target #5: Reduce Alaska's unintentional injury death rate to 50/100,000 population.

Measure #5: Unintentional injury death rate.

Unintentional injury death rate per 100,000 population

Year	Alaska	US
1999	57.5	35.3
2000	63.9	34.9
	+11.13%	-1.13%
2001	61.1	35.6
	-4.38%	+2.01%
2002	59.2	36.9
	-3.11%	+3.65%
2003	55.1	37.2
	-6.93%	+0.81%
2004	54.9	36.6
	-0.36%	-1.61%
2005	50.6	38.1
	-7.83%	+4.10%
2006	48.5	N/A
	-4.15%	

U.S. data will be updated once it is approved and released by the CDC's National Center for Health Statistics.

Analysis of results and challenges: Injuries are a significant public health and social services problem because of the prevalence of injuries, the toll of injuries on the young, and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries. Unintentional injuries are the third leading cause of death in Alaska. Unlike cancer and heart disease, which are the leading causes of death among the elderly, injuries are the leading cause of death in children and young adults.

The Division of Public Health along with its many partners continues to see the benefits of actions related to injury control and prevention. The Safe Boating Act and Kids Don't Float are only two examples of the activities that contribute to success in reaching and maintaining this target. The Division of Public Health's Injury Control program will continue to partner with others and to use surveillance and prevention strategies to understand and target interventions.

A1: Strategy - Reduce the risk of epidemics and the spread of infectious disease.

Target #1: 95% of persons with TB will complete adequate treatment within one year of beginning treatment. **Measure #1:** Percent of persons with TB completing treatment regimen.

% of Persons with TB Completing Treatment Regimen

Year	Annual
2002	93%
2003	93%
2004	86%
2005	92%
2006	50%*

^{*}TB treatment requires 6-9 months for completion. 2006 completion data are still being collected.

Analysis of results and challenges: The highest priority for TB control is to ensure that persons with the disease are diagnosed early and complete curative therapy. If treatment is not continued for a sufficient length of time, people with TB become ill and contagious again, sometimes with resistant TB the second time. Completion of therapy is essential to prevent transmission of the disease as well as to prevent the development of drug-resistant TB. The measurement of completion of therapy is an important indicator of the effectiveness of community TB control efforts.

Target #2: At least 98% of chlamydia cases will be prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines.

Measure #2: Percent of persons with chlamydia prescribed adequate treatment regimen.

% of Chlamydia cases prescribed adequate treatment

Year	Annual
2003	99.5%
2004	99.6%
2005	99.8%
2006	97.9%

Analysis of results and challenges: HIV/STD program staff follow up to assure adequate treatment is prescribed for all reported chlamydia cases. Given such follow up, few cases are ultimately treated in a manner inconsistent with the national guidelines. Challenges include maintaining resources necessary to conduct necessary follow up and carefully monitoring disease trends to identify emerging problems.

The proportion of chlamydia cases prescribed adequate treatment dropped slightly in 2006, due primarily to individuals refusing treatment or an inability to locate them. There were a total of 4,528 reported chlamydia cases in 2006, compared to 4,356 in 2005.

A2: Strategy - Reduce suffering, death and disability due to chronic disease.

Target #1: Less than 17% of high school youth in Alaska smoke. **Measure #1:** Prevalence of smoking among Alaskan youth.

Prevalence of tobacco use in Alaska youth in past 30 days (per YRBS survey)

Year	Alaska	US
1999		34.8
2001		28.5 -18.10%
2003	19.2	21.9 -23.16%
2005	0 -100.00%	23.0 +5.02%
2007	17.8 0%	0 -100.00%

Data is collected every other year. Alaska data not released in years when a statistically valid sample is not available. U.S. data will be reported when released by the CDC.

Analysis of results and challenges: Many Alaskans are currently at risk for developing cardiovascular disease due to such risk factors as smoking, being overweight, poor diet, sedentary lifestyle, high blood pressure and cholesterol, and lack of preventive health screening. Smokers' risk of heart attack is more than twice that of nonsmokers. Chronic exposure to environmental tobacco smoke (second-hand smoke) also increases the risk of heart disease. Cigarette smoking is also an important risk factor for stroke.

Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20 years. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, enforcement of laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

In 1995, 37% of Alaska youth reported smoking at least once in the last thirty days, compared with 19.2% in 2003 and 17.8% in 2007. Data is available from the Youth Risk Behavior Survey when enough Alaska schools participate to give results that can be generalized to the high school population as a whole in the state. This was the case only in 1995, 2003 and 2007. Surveys occurred in other years, however, schools did not have enough participants to provide statewide results. It is the goal of the Division of Public Health to continue to work with schools to collect a representative sample every other year.

Healthy Alaskans 2010 target is 17.0%.

A3: Strategy - Reduce suffering, death and disability due to injuries.

Target #1: Increase seatbelt use to 80%.

Measure #1: Percent of properly restrained occupants in a motor vehicle.

Seat Belt Use by Drivers and Passengers

Year	Alaska	US
1999	60.6%	67%
2000	61.3%	71%
2001	62.6%	73%
2002	65.8%	73%
2003	78.9%	79%
2004	77.0%	80%
2005	78.4%	82%
2006	82.4%	81%

Analysis of results and challenges: Injuries are a significant public health and social services problem because of their prevalence, the toll of injuries on the young and the high cost in terms of resources and

suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries and death. Unintentional injuries are the third leading cause of death in Alaska.

Studies have shown that a primary seatbelt enforcement law that allows police to stop and cite motorists for failing to comply with the seatbelt law is most effective in reaching a higher level of seatbelt use compliance.

The Alaska Legislature began its 2006 session by passing such a law, which took effect May 1, 2006. In addition, efforts are ongoing to increase seatbelt use through public information messages and other targeted activities.

The Healthy Alaskans 2010 target is 80 percent seatbelt usage.

A4: Strategy - Assure access to early preventative services and quality health care.

Target #1: More than 60% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects.

Measure #1: Percent of women reporting knowledge of folic acid benefits.

Knowledge of Folic Acid Benefits, Alaska

Year	Overall	Alaska Native
2000	80.8	62.3
2001	80.5	63.1
	-0.37%	+1.28%
2002	80.8	63.5
	+0.37%	+0.63%
2003	82.0	65.3
	+1.49%	+2.83%
2004	81.8	68.4
	-0.24%	+4.75%
2005	81.4	66.1
	-0.49%	-3.36%

Analysis of results and challenges: Since 2000, the knowledge of folic acid benefits among Alaska mothers has remained at about the same level, around 81% to 82%.

The proportion of Alaska Native mothers who know about the benefits of folic acid steadily increased to 68.4% in 2004, then fell slightly to 66.1% the following year. Numbers for 2006 still are not available. While the prevalence of folic acid knowledge among Alaska Native mothers of newborns was still substantially lower than overall levels, the gap in knowledge between Alaska Natives and Alaskan mothers overall appears to be closing in recent years.

For women of childbearing age, increasing folic acid use by taking multivitamins before and during pregnancy can reduce the risk of neural tube birth defects. Numerous public education campaigns have sought to increase women's knowledge of the benefits of folic acid supplementation and educate them especially about the importance of the timing (pre-pregnancy supplementation is ideal). Efforts should focus on increasing the overall knowledge prevalence to 90% and minimizing racial disparities.

Target #2: 100% of Alaska's licensed and certified long-term care facilities are surveyed and recertified annually.

Measure #2: Percent of licensed and certified long-term care facilities surveyed and recertified annually.

% of licensed and certified long-term care facilities surveyed and re-certified annually

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	42.86	21.43	21.43	14.29	100%
2003	21.43	42.86	14.29	21.43	100%
2004	35.71	21.43	21.43	14.29	92.86%
2005	26.67	33.33	13.33	20	93.33%
2006	20	26.7	40	20	106.7%
2007	6.67	20	40	26.67	93.34

Analysis of results and challenges: The annual required schedule for nursing home surveys is driven in large part by federal certification requirements. Surveys are to be completed within a 9- to 15-month period. Certification and Licensing (C & L) may not appear to meet the licensing and certification goal within a given calendar or fiscal year, or sometimes it may be over 100%. However, C & L will consistently meet federal and state certification and licensing survey requirements. The section's scheduling is affected by significant increases or decreases in complaints or reports of harm, and by significant changes in staff resources.

A5: Strategy - Minimize loss of life and suffering from natural disasters and terrorist attack.

Target #1: 25% of the Division of Public Health (DPH) staff is trained in disaster response techniques and procedures.

Measure #1: Percent of DPH staff trained.

and % of Division of Public Health staff trained in disaster preparedness

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
FY 2005			70	103	27%
FY 2006				144*	28%
FY 2007	27	106	17	31 0%	35%
FY 2008	69 +155.56%	0 -100.00%	0 -100.00%	-100.00%	69 0%

^{*144} Division of Public Health staff received disaster preparedness training in FY2006. Quarterly numbers were not available.

Analysis of results and challenges: Disaster response training for Division of Public Health (DPH) staff is enabling DPH to carry out its role in disaster response operations. Training is the critical link between planning and action, and permits all concerned to maintain a common knowledge base.

The FY07 percentage reflects the following: 520 total DPH positions, with an estimated 181 individuals receiving disaster preparedness training - for a total of 35 percent trained. This meets the division goal of 25 percent annually. However, when only filled positions are considered (approximately 425 at the end of FY07), then the total of DPH-trained staff for FY07 to date increases to 42 percent.

A6: Strategy - Reduce Alaskans' exposure to environmental human health hazards.

Target #1: State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals.

Measure #1: Each new testing method validated as required by Clinical Laboratory Improvement Amendments (CLIA).

% testing methods for PCBs, pesticides and heavy metals validated by CLIA

Year	Target	Actual
2004	10%	10%
2005	75%	50%
2006	75%	50%
2007	75%	60%

Analysis of results and challenges: PCBs, pesticides and trace heavy metals can affect human health, especially that of the developing fetus. The chief concern in Alaska centers on the presence of contaminants in traditional foods. Generally these foods are very nutritious and offer a number of health benefits. This testing measures human exposure to contaminants and verifies the safety of traditional foods. For years, the federal government, through the Clinical Laboratory Improvement Amendments (CLIA) process, has certified the state lab. However, no chemical testing (for PCBs, etc.) was offered at the lab until 2004. Now the lab conducts CLIA-certified testing of inorganics, and some testing for Persistent Organic Pollutants (POPs) is underway.

Senior and Disabilities Services Results Delivery Unit

Contribution to Department's Mission

The mission of the Division of Senior and Disabilities Services is to promote the independence of Alaska's seniors and people with physical and developmental disabilities.

Core Services

- 1) Institutional and community-based services for older Alaskans and persons with disabilities.
- 2) Protection of vulnerable adults.

End Result	Strategies to Achieve End Result
A: Improve and enhance the quality of life for seniors and persons with disabilities through cost-effective delivery of services.	A1: Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only
Target #1: Reduce % of Medicaid recipients not receiving medical assessments to less than 5%. Measure #1: % of clients not receiving medical review.	receive the services they are eligible to receive.
End Result	Strategies to Achieve End Result
B: Promote improved service and compliance with federal/state regulations through provider agencies. Target #1: Reduce incidence and severity of errors resulting in audit findings by 10% by providing adequate training to provider agencies. Measure #1: Show an overall reduction in error rates from audit findings from current rate by 10%.	B1: Develop, implement and maintain an on-going system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide eight care coordination training sessions each year in Alaskan communities.
End Result	Strategies to Achieve End Result
C: Ensure manageable caseload number in Adult Protective Services (APS) and Quality Assurance Units to provide timely investigations.	
Target #1: Reduce APS staff assigned case loads by 10%. Measure #1: Annual cases assigned to each case worker.	
Target #2: Reduce length of time a case is "open" by 10%. Measure #2: Length of days required to close an "open" case.	

FY2009 Resources Allocated to Achieve Results		
FY2009 Results Delivery Unit Budget: \$376,793,000	Personnel: Full time	119
	Part time	1
	Total	120

Performance Measure Detail

A: Result - Improve and enhance the quality of life for seniors and persons with disabilities through cost-effective delivery of services.

Target #1: Reduce % of Medicaid recipients not receiving medical assessments to less than 5%. **Measure #1:** % of clients not receiving medical review.

SDS Outstanding Medicaid Assessments (FY05-FY07)

Year	% Not Reviewed
FY 2005	30.9%
FY 2006	23.18%
FY 2007	4.50%

This chart shows the percentage of Senior and Disabilities Services Medicaid recipients that have not been assessed using a standardized assessment tool by an objective assessor from FY05-FY07.

Analysis of results and challenges: The Personal Care Attendant (PCA) program was the only Medicaid program that did not require a state-approved medical assessment to receive services until implementation of new regulations in April of 2006. These new regulations began requiring a state-approved medical assessment and prior authorization of Medicaid benefits to ensure that beneficiaries are only receiving the services they are eligible to receive. This table shows the percentage of outstanding Medicaid assessments from FY2005-2007. Senior and Disabilities Services (SDS) has worked hard to catch up on back-logged Medicaid Waiver assessments through a contractor, state staff authorized to perform assessments and through agencies with staff on-site that have the appropriate credentials to complete assessments. In spite of these efforts, there were too many pending assessments required when new regulations went into effect in April of 2006 for the Personal Care Attendant program. SDS has dramatically decreased the assessment back-log but will not be caught up until all recipients receiving PCA services have been assessed. SDS will work hard to be fully caught up with all pending assessments by the end of FY08.

A1: Strategy - Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only receive the services they are eligible to receive.

B: Result - Promote improved service and compliance with federal/state regulations through provider agencies.

Target #1: Reduce incidence and severity of errors resulting in audit findings by 10% by providing adequate training to provider agencies.

Measure #1: Show an overall reduction in error rates from audit findings from current rate by 10%.

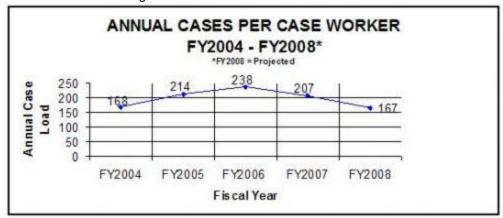
Summary of Myers and Stauffers FY05 & FY06	Error Rate Fiscal Year 2005	Error Rate Fiscal Year 2006
Skilled Nursing	8.55%	0.00%
Home & Community Services	18.53%	6.33%
Assisted Living	26.28%	16.14%
Care Coordination	16.23%	1.61%
Personal Care	14.42%	4.75%
SDS Total	15.83%	6.43%

Analysis of results and challenges: The chart shows SDS Medicaid programs that have been audited by Myers and Stauffer and the percentage of audit exceptions that have been assigned to each program. These audit numbers are preliminary until the provider agencies have had a chance to respond, so these numbers should decrease as providers respond to the findings. However, it does show that significant improvement was made in the error rates across SDS programs from FY05 to FY06. In FY07 and FY08, Senior and Disabilities Services has been working with provider agencies to help provide them with the training and support they need to improve their error rates noted in FY05 and FY06.

B1: Strategy - Develop, implement and maintain an on-going system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide eight care coordination training sessions each year in Alaskan communities.

C: Result - Ensure manageable caseload number in Adult Protective Services (APS) and Quality Assurance Units to provide timely investigations.

Target #1: Reduce APS staff assigned case loads by 10%. **Measure #1:** Annual cases assigned to each case worker.



Adult Protective Services Caseloads

Year	Total Investigations	Full Time Workers	Annual Cases/Worker	Days to Investigate
FY 2004	1173	7	168	0
FY 2005	1497	7	214	0
	+27.62%	0%	+27.38%	0%
FY 2006	1666 +11.29%	7 0%	238 +11.21%	2.6 0%
FY 2007	1866 +12.00%	9 +28.57%	207 -13.03%	2.1 -19.23%
FY 2008	2000 +7.18%	12 +33.33%	167 -19.32%	1.932 -8.00%

^{*}FY08 = projected numbers based on addition of new case worker staff and current estimated case load decrease of 8%.

Analysis of results and challenges: The annual caseload for an Adult Protective Services (APS) case worker was steadily on the rise from FY04 to FY06. From FY04 to FY05, the average caseload increased by more than 27%. From FY05 to FY06, the average caseload increased again, this time by more than 11%. From FY06 to FY07 the average caseload decreased by more than 13% after two new case workers were hired. Based on this unexpected growth, Senior and Disabilities Services has added five new positions since FY06. Because of these new positions, FY07 finally saw a decrease in the number of open cases per case worker. With additional new position in FY08, Senior and Disabilities Services expects to see a decrease to the number of annual cases per case worker. Senior and Disabilities Services will keep adding new positions until case loads for Alaska Adult Protective Services case workers are at a more manageable level.

Target #2: Reduce length of time a case is "open" by 10%. **Measure #2:** Length of days required to close an "open" case.

Days to Investigate Open Case

Year	Days to Investigated	YTD
2006	2.6	2.6
2007	2.1 -19.23%	2.1 -19.23%
2008	1.932 -8.00%	1.932 -8.00%

FY08 = Projected

Analysis of results and challenges: The average length of time it took to investigate a new case was approximately 2.6 days in FY06, when there were only seven case workers. In FY07, two additional case worker positions were added, bringing the average length of time to investigate a report of harm down to 2.1

days. In FY08, SDS added three additional positions, for a total of 12. With these new positions, Senior and Disabilities Services anticipates a decrease to the number of annual cases per worker of more than 13.75%. Senior and Disabilities Services anticipates that with additional new staff being added in FY08 that the number of days it takes to investigate a new case could drop to less than two days.

Departmental Support Services Results Delivery Unit

Contribution to Department's Mission

To provide quality administrative services that support the department's programs.

Core Services

Promote cost containment. Maximize revenue.

Provide divisions with necessary information to improve compliance with federal and state laws/policies to ensure our fiduciary responsibilities are met.

Improve Department of Health and Social Services (DHSS) staff knowledge and skills and maintain high morale to continually improve performance and services for Alaskans.

Provide efficient centralized administrative support to nine DHSS divisions; maintain offices in Juneau and Anchorage.

The components of the Department Support Services RDU contribute as follows:

- The Commissioner's Office component funds upper-level management and policy development for the entire department.
- The Public Affairs component ensures consistency and continuity in communication with stakeholders; helps promote health communications; provides transparency to the public regarding department activities; and responds to media, legislative and constituent inquiries.
- The Quality Assurance and Audit component conducts audits of Medical Assistance providers' claims; organizes and chairs functional Audit Committee; oversees the contract audits mandated under Alaska Statute 47.05.200; is the responsible departmental contact for the Center for Medicare and Medicaid Services; is the departmental contact for the Department of Law, Medicaid Fraud Control Unit (MFCU); manages the Payment Error Rate Measurement (PERM) and is part of the Leadership Team.
- The Office of Faith-Based and Community Initiatives component provides guidance, direction, support, and seeks financing to support faith-based and community initiative programs and services.
- The Health Planning Strategies Council component is to develop a Statewide Healthcare Action Plan to include a description of the current health care system in Alaska; an inventory and analysis of all existing private and public health care plans, reports and initiatives in Alaska; short-term and long-term strategies to address cost, quality and access to care; and performance measures and accountability mechanisms to provide policy makers with tools to assess the success of the strategic plans over time.
- The Assessment and Planning component core service is planning, assessment and forecasting activities for the Medicaid program.
- The Administrative Support Services component funds financial, budget, procurement, grant and professional service contract administration, information services and audit services as well as human resource liaison functions.
- The Hearings and Appeals component focuses on Health Care Facility appeals of Medicaid payment rates and audit findings.
- The Facilities Management component includes the management of the department's capital programs.
- The Facilities Maintenance component, Pioneer Homes Facilities Maintenance, and HSS State Facilities Rent

components record dollars spent to operate state facilities. These units collect costs for facilities operations, maintenance and repair, renewal and replacement as defined in AS 35 Public Buildings, Works, and Improvements, and pay rent fees for Rent Project.

- The Information Technology (IT) component focuses on improving the efficiency and effectiveness of IT services and developing a more capable IT organization for the department.
- The State Rent component core service is to pay rent on state-owned facilities.

End Result	Strategies to Achieve End Result
A: Facilitate the department's mission through superior (effective and efficient) delivery of administrative services.	
Target #1: The Department of Health and Social Services (DHSS) administration as a percentage of department overhead should be below 2%. Measure #1: Percentage administration personal services is to total department budget.	
Target #2: Process capital grant payments within five days. Measure #2: Number of days to process a grant payment after receiving reports.	
End Result	Strategies to Achieve End Result
B: Improve overall management of DHSS budget processes.	
Target #1: Improve legislative understanding of the DHSS budget. Measure #1: Respond to 80% of legislative inquiries by budget section within five working days.	
End Result	Strategies to Achieve End Result
C: Facilitate the department's day-to-day operations through effective and efficient delivery of services.	
Target #1: Reduce the length of time and number of days to respond and close out service calls. Measure #1: Number of days to close out service calls.	
Target #2: 85% of construction projects completed on time and within budget. Measure #2: Percentage of construction projects done on-time and within budget.	

FY2009 Resources Allocated to Achieve Results		
Personnel: Full time	361	
Part time	1	
Total	362	
	Personnel: Full time Part time	

Performance Measure Detail

A: Result - Facilitate the department's mission through superior (effective and efficient) delivery of administrative services.

Target #1: The Department of Health and Social Services (DHSS) administration as a percentage of department overhead should be below 2%.

Measure #1: Percentage administration personal services is to total department budget.

Percentage administration personal services is to total department budget

Year	YTD
2003	3.6%
2004	4.3%
2005	1.3%
2006	1.4%
2007	1.6%

Analysis of results and challenges: It is the goal of the Department of Health and Social Services (DHSS) to keep administrative costs as low as practicable.

Department administration personnel services equal all of Department Support Services RDU. This number is compared to the total DHSS expenditures.

Target #2: Process capital grant payments within five days.

Measure #2: Number of days to process a grant payment after receiving reports.

Number of days to process a grant payment after receiving reports.

Year	YTD
FY 2003	5.60 days
FY 2004	4.89 days
FY 2005	3.11 days
FY 2006	3.36 days
FY 2007	1.50 days
FY 2008	0.43 days

2008 only reflects first quarter.

Analysis of results and challenges: For FY06, there were 93 capital grant payments, all processing within five days. For FY07, there were 101 capital grant payments, all processing within five days.

B: Result - Improve overall management of DHSS budget processes.

Target #1: Improve legislative understanding of the DHSS budget.

Measure #1: Respond to 80% of legislative inquiries by budget section within five working days.

% of Responses for Legislative Requests made within five working days

Year	YTD
FY 2002	83%
FY 2003	83%
FY 2004	78%
FY 2005	79%
FY 2006	80%
FY 2007	72%
FY 2008	81%

2008 only reflects first quarter.

Analysis of results and challenges: It is important that policy makers working on key budget issues get their information timely in order to make decisions regarding the DHSS budget.

The budget section received approximately 147 requests in CY 2003, 186 in CY 2004 and 236 in FY 2005.

In previous years (2002 to 2004) the data was reported by calendar year, but starting in (2005) the data is collected by fiscal year. The average processing time in FY 2006 was 3.52 days and 80% were completed within five working days.

In FY 2007, the number of requests increased from 179 to 191, and there were a number of complex requests that required a week or more to complete, resulting in an overall increase to the average number of days to respond. With the increased processing time and increased number of requests, the budget section still averaged a 4.16 day turnaround in responding to legislative budget requests even though the percentage of those responded to within five working days went down.

C: Result - Facilitate the department's day-to-day operations through effective and efficient delivery of services.

Target #1: Reduce the length of time and number of days to respond and close out service calls.

Measure #1: Number of days to close out service calls.

Average Number of Days to Complete Service

Year	YTD
FY 2005	8.2 days
FY 2006	4.9 days
FY 2007	7.1 days

FY 2005 data represents only 3 quarters. This measure began at the start of the 2nd quarter. FY 2006 contains a full year.

Analysis of results and challenges: This measure was developed at the start of the second quarter in FY05. It is important to note that FY05 was the first year of integrated service delivery and not all divisions were in the system. In 2006, all divisions were in the system; the data was consistent and showed a 50% improvement in turnaround time.

There are a total of 15 categories of work/service performed that have been used to calculate the above averages. (In the second quarter there were only 13 categories tracked.)

Examples of categories are, but not limited to: setting up accounts; application work; password setup; procurement of equipment; relocation of equipment; security; software; web; hardware or file maintenance, etc.

In FY07, although the days to respond to a service request increased nearly 50%, the number of service calls went from 4,843 in FY06 to 7,334 for FY07. Additionally, during this past year the department underwent a major statewide, from Ketchikan to Barrow, desktop refresh within the department. While customer service staff was deployed to this priority project, some delays resulted in routine service call response times.

Target #2: 85% of construction projects completed on time and within budget. **Measure #2:** Percentage of construction projects done on-time and within budget.

Percent of Completed Construction Projects On Time and Within Budget.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
FY 2006	100%	100%	56%	85%	85.25%
FY 2007	64%	56%	78%	80%	73.00%
FY 2008	70%	0	0	0	70.00%
		0%	0%	0%	

2008 only reflects first quarter.

Analysis of results and challenges: The Department began tracking construction projects in FY06.

In FY07, although the overall percentage of completed construction projects was lower than FY06, these projects were still completed in a timely manner. The timeline on these dropped due to staffing shortages and the inability to recruit and fill needed professional positions.